357098

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

85 3278 5

1- FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Benjamin	MIDDLE: Otis	LAST: Aiken	2a. DATE KNOWN OF DEATH ESTIMATED ☐	MONTH: 12 DAY: 4 YEAR: 19 85	2b. HOUR: 4:20 PM
3. SEX: M	4. RACE: W	5. DATE OF BIRTH MONTH DAY YEAR: 7/19/1899	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: 12 4 19 85	2d. HOUR: 4:20 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Elem. School				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Garrett	13c. CITY OR TOWN: Accident	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt 1 Box 18 Accident Md. 21520			
14. FATHER'S NAME FIRST: Rufus	MIDDLE: ~~XXX~~ Judson	LAST: Aiken	15. MOTHER'S MAIDEN NAME FIRST: Nora	MIDDLE: ---	LAST: ~~Hester~~		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WW IX	16b. SOCIAL SECURITY NO.: 219-36-8375	17. INFORMANT: Mrs. Hildegarde Aiken	ADDRESS: Route 1, Box 18 Accident, MD 21520			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Francisco Reyes M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED:

EXAMINER'S NAME (TYPE OR PRINT): Francisco Reyes ADDRESS: 900 Seton Dr. Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/7/85	23c. NAME OF CEMETERY OR CREMATORY: Zion Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Accident, Garrett MD 21502
24. FUNERAL DIRECTOR NAME: A. Lynn Newman ADDRESS: Grantsville, MD 21536	25a. DATE REC'D BY REGISTRAR: DEC 17 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

365197

BOALS FUNERAL HOME
1 - FOR STATE REGISTRAR 111 CHURCH ST. WESTERNPORT, MD.

85 327860

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b HOUR
PAUL	FERDINAND	AMANN	DECEMBER 13,1985	6:45 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Male	White	12 30 1907	77 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8	9 BALTIMORE CITY OR COUNTY OF DEATH
Maryland	usa	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Ret. Westvaco	Paper

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Westernport	YES ☒ NO ☐	274 Main St. 21562

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
John Amann	Annie Kady

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
yes	WW2	217-05-0113	Mrs. Elizabeth Amann	Westernport, M.d 21562

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from ______, 19____ to ______, 19____, that (I) (we) last saw the deceased alive on ______ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c DATE SIGNED
George Brega MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒	12-16-85

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
EUGENE V. MAZZOCCO,MD	BMG 912 SETON DRIVE CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Burial	12/16/85	St. Peters Cemetery	Westernport Allegany Md.

24 FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wayne Buck — Boals Funeral Service Westernport, Md. 21562	DEC 20 1985	Julia [illegible]

BP________

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon [illegible]. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic [illegible] medical examiner [illegible]

B

350106

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32787
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state. In any event, the medical portion must be mailed at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical portion must be mailed at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: PRUDY	MIDDLE: L.	LAST: ANDERSON	2a. DATE OF DEATH MONTH DAY YEAR: December 7, 1985	2b. HOUR: 7:35 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 15 1895	6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: W.Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Keyser	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 500 Carskadon Lane 99999	
14. FATHER'S NAME FIRST: William	MIDDLE: E.	LAST: Parks	15. MOTHER'S MAIDEN NAME FIRST: Sarah	MIDDLE	LAST: Hall
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO: 236-76-0996	17. INFORMANT: Mr. Herbert Anderson	ADDRESS: 97 James St. Keyser, W.Va. 26726	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Intractable Congestive heart Failure

DUE TO, OR AS A CONSEQUENCE OF (b): Advanced CAD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Multiple Pulmonary Embolesm, COPD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 12/1/85 to 12/7/85, that I (we) last saw the deceased alive on 12/7/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Shawn A Matteson DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 12/8/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Raver

22e. ADDRESS: 500 Memorial Ave., Memorial Med. Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Entombment	23b. DATE: Dec. 13, 1985	23c. NAME OF CEMETERY OR CREMATORY: Sylvan Abbey Mem. Park	23d. LOCATION CITY OR TOWN: Clearwater	COUNTY	STATE: Fla.
24. FUNERAL DIRECTOR: Donald W. McKenzie	ADDRESS: 111 S. Mineral Keyser, W.Va.	25a. DATE REC'D. BY REGISTRAR: DEC 13 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson Rogers		

Wood-McKenzie Funeral Home

BP 99999

DHMH - 16 60M 7/84 (VRA 15, 4)

352142

ZEIGLER FUNERAL HOME
HYNDMAN, PA
15545

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32788

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
GOLDIE	MARIE	APPLING	DECEMBER 5, 1985	7:35 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH / DAY / YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	Caucasian	10 / 07 / 1914	71 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
PA	USA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Homemaker	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
PA	Bedford	Hyndman	YES ☐ NO ☒	Box 579, R D 1/ 15545

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph		Divelbiss	Cassie	Belle	Deneen

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		213 22 3491	Linda Appling, Box 579, RD, Hyndman, PA 15545

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure & pulmonary edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) ehd
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
Mild emphysema ; diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/16 19 85 to 12/5 19 85 that (I) (we) last saw the deceased alive on 12/5 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/5/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RENATO ESPINA, MD	907 SETON DRIVE, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12/7/85	Sunset Memorial Park	Cumberland, Allegany, MD

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler	Hyndman, PA 15545	DEC 10 1985	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The plastic inner carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, poisoning, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

352125

SILCOX MERRITT FUNERAL HOME
404 DECATOR STREET
CUMBERLAND, MD 21502

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32789

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain these two pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): FIRST ELIZABETH; MIDDLE EDNA; LAST BARRY
2a. DATE OF DEATH: MONTH DECEMBER; DAY 11; YEAR 1985
2b. HOUR: 1:50 AM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH NOVEMBER; DAY 20; YEAR 1911
6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE: 9 RIDGEWAY TERRACE 21502

14. FATHER'S NAME: FIRST JAMES; MIDDLE W.; LAST MILLER
15. MOTHER'S MAIDEN NAME: FIRST BESSIE; MIDDLE LEE; LAST VALENTINE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 217-10-6986
17. INFORMANT ADDRESS: JAMES P. BARRY 9RIDGEWAY TERRACE CUMBERLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Arteria Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b): with Cardiogenic shock.
DUE TO, OR AS A CONSEQUENCE OF (c): H of CAD c pleuring MI
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
Generalized Arteriosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Type II

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

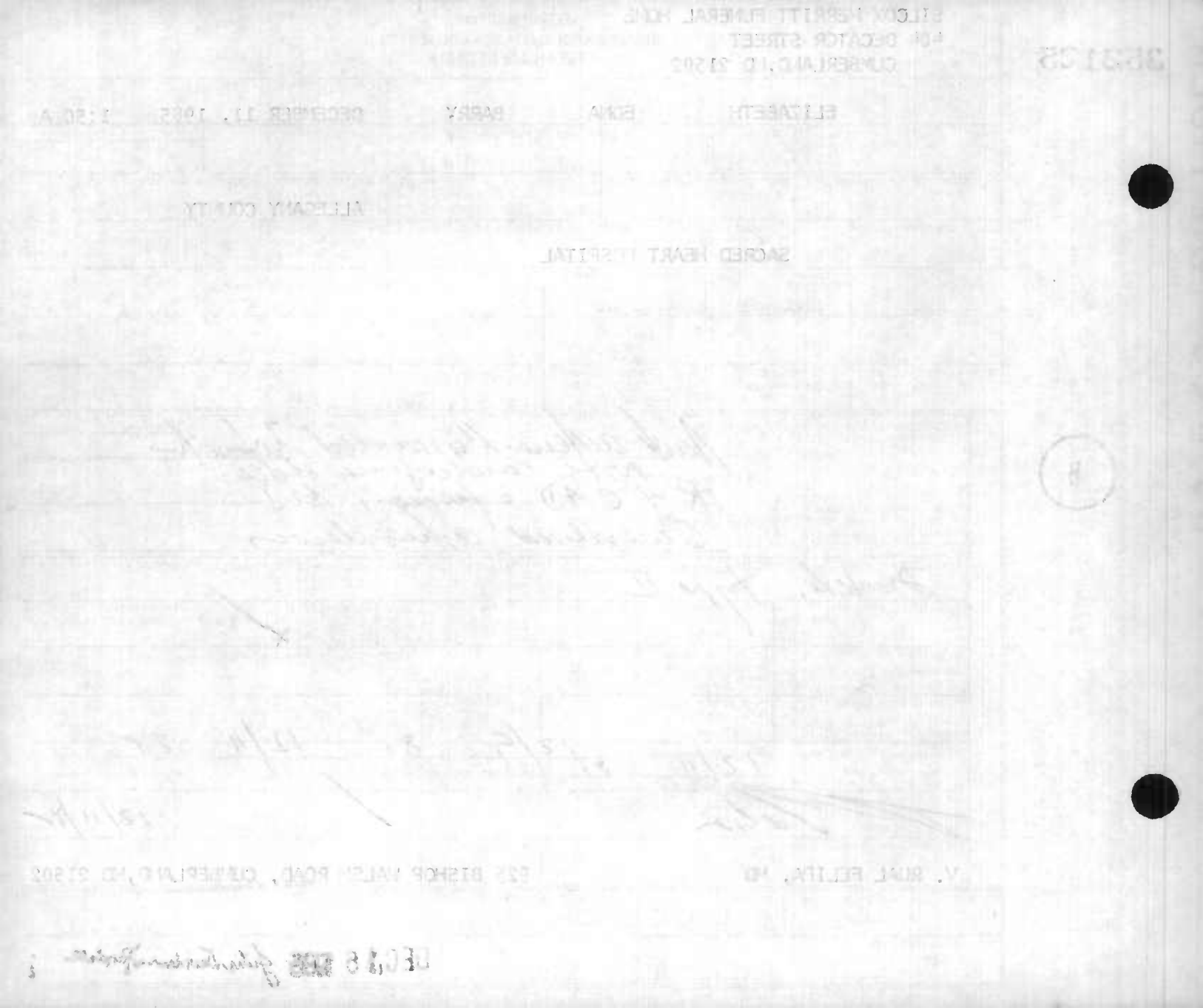
22a. I certify that (I) (this hospital) attended the deceased from 12/9 19 85 to 12/11 19 85, that (I) (we) last saw the deceased alive on 12/11 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: V. Felipa
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/11/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. RUAL FELIPA, MD
22e. ADDRESS: 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: DEC 13 1985
23c. NAME OF CEMETERY OR CREMATORY: ST MICHAEL's CEMETERY
23d. LOCATION CITY OR TOWN: FROSTBURG; COUNTY: ALLEGANY; STATE: MARYLAND

24. FUNERAL DIRECTOR NAME AND ADDRESS: SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.
25a. DATE REC'D BY REGISTRAR: DEC 16 1985
25b. REGISTRAR'S SIGNATURE: Julia Davidson Spradlin

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)



351074

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32790

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
SUSAN	ADELE	BATES	DECEMBER 9,1985	11:45A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	Black	June 18 1932	53 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Allegany County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Teacher's Aide	Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cumberland	YES ☒ NO ☐	Apt. 7-D Fort Cumberland Homes 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ernest	O.	Bates	Florence	---	Jones

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		217-30-1945	Cumberland, Md. 21502 Nancy Bates 355 Williams St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Advanced Ca. tongue — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/9/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. ZAMAN	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-12-85	Sunset Memorial P.	Cumberland Allegany Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leasure-Stein Inc. 230 Baltimore Ave. Cumberland, Md. 21502	DEC 13 1985	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

357043

1 - FOR STATE REGISTRAR

HAFER FUNERAL HOME
1302 NATIONAL HWY.
LAVALE, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32791
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	2a. DATE OF DEATH MONTH / DAY / YEAR	2b. HOUR
PAUL THEODORE BECKWITH	DECEMBER 15, 1985	2:37 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH / DAY / YEAR	6. AGE (IN YEARS LAST BIRTHDAY) / IF UNDER 1 YEAR MONTHS / DAYS / IF UNDER 24 HRS. HOURS / MIN.
Male	White	11- 29- 1903	82 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
Ohio	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Rigger	Manufacturing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Ohio	Trumbull	Niles	YES [X] NO [ ]	10 Sheridan Ave. 21502

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Frank Beckwith	Emma Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		220-10-9091	Agnes S. Beckwith same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-Respiratory Failure	5 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Bilateral Cerebral Infarction	
DUE TO, OR AS A CONSEQUENCE OF (c)	Bilateral CVA. Carotid arterio sclerosis	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
Diabetes mellitus; Septicemia. Congestive failure acute Renal Failure, old age

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/6/85, 19__, to 12/15, 19 85, that (I) (~~saw~~) last saw the deceased alive on 12/14/1985, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~saw~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
S C Sandhir MD	[ ] [X] [ ]	12/15/1985

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SIKANDER SANDHIR	48 TARN TERRACE FROSTBURG, MD 21532

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 17, 85	Pineview	Warren Trumbull, Ohio

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer LaVale, Md. 21502	DEC 19 1985	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 4/83
(VRA 15, 4)

364134

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32792

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be stapled with page 3 and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST: KATHLEEN	MIDDLE: MAE	LAST: BIERMAN	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 16, 1985		2b. HOUR: 1:45P.M
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: 09-08-1910	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WV	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife		12b. KIND OF BUSINESS OR INDUSTRY: own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES [ ] NO [X]	R.F.D. 4 - Mexico Farms/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Clifton E. Willison	Cora M. Emerick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		217-10-4783	Mr. Frederick W. Bierman, Jr., Cumberland, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ADENOCARCINOMA OF COLON WITH METASTASIS.

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. TORRES	Memorial Hospital Medical Building Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-19-1985	Hillcrest Burial Park	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 19 1985	Julia Davidson Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

365176

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32193

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and separate pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Edward Charles Bock				2a. DATE OF DEATH MONTH DAY YEAR: 12 13 85	2b. HOUR: 7:47 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 16, 1902	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Frostburg Village Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Saw & Mower Repair Shop		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 430 Valley St. 21502	
14. FATHER'S NAME FIRST / MIDDLE / LAST: George Bock		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Barbara O'Baker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217-10-1498	17. INFORMANT ADDRESS: Mrs. Elizabeth Bock, Cumberland, Md. Wife		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASCVD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 years
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George Breza MD	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 12-16-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): George Breza, MD	22e. ADDRESS: 912 Seton Drive, Cumberland, Md. 21502		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12-16-1985	23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. DATE REC'D. BY REGISTRAR: DEC 19 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson Register	

BP_____

DHMH-16 25M
(VRA 15, 4) 1/79

351114

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32794

1 - FOR STATE REGISTRAR — HAFER FUNERAL HOME 1302 NAT. HWY. LAVALE, MD

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ALICE	JUNE	BOWMAN	DECEMBER 9, 1985	2:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Aug. 11, 1933	52 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
W. VA.	USA		ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Housewife	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cresaptown	YES X NO ☐	14906 Lone Oak St./21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Harry	Vernon	Kesecker	Martha	Estella	Fearnow

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		220287670	Roger D. Bowman - same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Brain Metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Ca of breast c Mets

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-02 19 85, to 12-9 19 85, that (I) (we) last saw the deceased alive on 12-9 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John Mehanna	M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-10-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
JOHN MEHANNA, M.D.	909-B SETON DRIVE CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/12/85	Sunset Mem. Park	Cumberland, Alleg., MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr.	LaVale, MD	DEC 13 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with(in) 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before disposition.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

353132

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 32795

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR 6:30 P M
IDA	H.	BRODBECK	12/5		85	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
FEMALE	WHITE	3/15/93	92 YRS.			12/5 19 85	6:30 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.		ALLEGANY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
NATIONAL	RT. 1, BOX 344, FROSTBURG	HOUSEWIFE	OWN HOME				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS			21532
MARYLAND	ALLEGANY	NATIONAL		RT. 1, BOX 344, FROSTBURG			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST		
WILLIAM		WARE	MARY	JANE	TAYLOR		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT			FROSTBURG, MD 21532	
NO	N.A.	214-01-6697	MRS. NAOMI INGRODI, RT. L, BOX 344				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CANCER OF THE RECTUM WITH METASTASIS	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Francisco Reyes M.D. TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER DATE SIGNED 12/5/85

EXAMINER'S NAME (TYPE OR PRINT) FRANCISCO REYES ADDRESS 900 Seton Dr. Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	12/8/85	FROSTBURG MEM. PARK	FROSTBURG ALLEGANY MD	21502
24. FUNERAL DIRECTOR (SIGNATURE) Howard M. Sowers ADDRESS 60 W. MAIN ST.		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
SOWERS FUNERAL HOME FROSTBURG		DEC 10 1985		

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

365221

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

85 32790 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Georgia; MIDDLE: May; LAST: Burdock

2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] — MONTH: 12; DAY: 18; YEAR: 1985

2b. HOUR: 9:50 a M

3. SEX: female

4. RACE: white

5. DATE OF BIRTH — MONTH: 02; DAY: 14; YEAR: 1918

6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. — IF UNDER 1 YR. MONTHS: ; DAYS: ; IF UNDER 24 HRS. HOURS: ; MIN.:

2c. DATE PRONOUNCED DEAD — MONTH: 12; DAY: 18; YEAR: 1985

2d. HOUR: 9:50 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WV

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): clerk

12b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 925 Grand Avenue/21502

14. FATHER'S NAME — FIRST: Walter Glaze, Sr.; MIDDLE: ; LAST:

15. MOTHER'S MAIDEN NAME — FIRST: May Davy; MIDDLE: ; LAST:

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES): no

16b. SOCIAL SECURITY NO.: 800-05-4394

17. INFORMANT — ADDRESS: Mrs. Anna May Swauger, Bowling Green, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Mycardial infarction due to

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b): arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [XX], Inquiry [XX], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Giovanni Mastrangelo M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12-18-85

EXAMINER'S NAME (TYPE OR PRINT): Giovanni Mastrangelo, M.D. ADDRESS: 900 Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 12-21-1985

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION CITY OR TOWN: Thomas COUNTY: STATE: WV

24. FUNERAL DIRECTOR NAME AND ADDRESS: Scarpelli Funeral Home, Cumberland, MD 21502

25a. DATE REC'D. BY REGISTRAR: DEC 23 1985

25b. REGISTRAR'S SIGNATURE:

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES: 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FEE; AND PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

006154

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32797
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JAMES	ROBERT	CANFIELD	2a. DATE OF DEATH MONTH DAY YEAR	DECEMBER 24, 1985
2b. HOUR	10:25 A				
3. SEX	male	4. RACE	white	5. DATE OF BIRTH MONTH DAY YEAR	03-24-1901
6. AGE (IN YEARS LAST BIRTHDAY)	84 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	WV	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.				
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (KIND OF WORK DONE MOST OF WORKING LIFE)	Ret. Brakeman
12b. KIND OF BUSINESS OR INDUSTRY	Railroad				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD	13b. COUNTY	Allegany	13c. CITY OR TOWN	Cumberland
13d. INSIDE CITY LIMITS? YES [X] NO [ ]		13e. STREET ADDRESS / ZIP CODE	220 W. Oldtown Road/21502		
14. FATHER'S NAME FIRST / MIDDLE / LAST	James R. Canfield	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Melissa Ann Bright		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	yes	(IF YES, GIVE WAR OR DATES)	1924-1928	16b. SOCIAL SECURITY NO.	214-05-8443
17. INFORMANT ADDRESS	Mrs. Emma J. Canfield, Cumberland, MD - wife				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic shock.
DUE TO, OR AS A CONSEQUENCE OF (b) Massive Anti MI
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypothyroidism, Dehydration

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED	12/24/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Dr. Ranjithan	22e. ADDRESS	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	12-27-1985	23c. NAME OF CEMETERY OR CREMATORY: Frostburg MemorialPk
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Frostburg Allegany MD			
24. FUNERAL DIRECTOR NAME / ADDRESS	James F. Scarpelli, Cumberland, MD 21502	25a. DATE REC'D. BY REGISTRAR	DEC 30 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

347003

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32798

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MARGARET	GRACE	CATHELL	December 1, 1985	3:50 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	April 9, 1916	69 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
W.Va.	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	MEMORIAL HOSPITAL	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
W.Va.	Mineral	Keyser	YES ☒ NO ☐	62 Vernon St. 26726

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	---	Cox	Nan	-----	(Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		234-56-5212	Mr. William E. Cathell	62 Vernon St. Keyser, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PROBABLY MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

DUE TO, OR AS A CONSEQUENCE OF (b) CAD —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: SEVERE CHRONIC BRONCHITIS & COR PULMONALE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from NOV 30 85, 19__ to DEC 1 85, 19__, that (I) (we) last saw the deceased alive on DEC 1, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I)(We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
James M Raver	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/3/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. James Raver	Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/3/85	Rest Lawn Mem. Park	LaVale Allegany Md.

24. FUNERAL DIRECTOR - NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Markwood-McKenzie Funeral Home	111 S. Mineral St. Keyser, W.Va. 26726	DEC 9 1985	Julia Davidson-Rader

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

006110

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32799

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ANTHONY	S	CLAY	12-21-85	6 35 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
MALE	white	06-21-1907	78 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Frostburg Village Nursing HOme	retired	railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	Allegany	Cumberland	YES ☒ NO ☐	452 Pennsylvania Avenue/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anthony Leo Clay	Mary Elizabeth Potts

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		214-05-9384	Mrs. Mary Clay, Cumberland, MD - wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF PROSTATE

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

AORTIC STENOSIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
H Sidhu	M.D	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	12-21-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
HARJIT S. SIDHU	48 TARN TERRACE, FROSTBURG MD, 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12-24-1985	St. Marys Cemetery	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James J. Scappelli Jr.	Cumberland Md	DEC 27 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH-16 25M
(VRA 15, 4) 1/79

345138

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32800

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b HOUR
MARY	JANE	COLEMAN	December 2, 1985	7:25 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
FEMALE	NEGRO	10/3/20	65 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	HOUSEKEEPER	HOME PRIVATE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	FROSTBURG	YES X NO ☐	83 BEALL ST. 21532

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
HARRY		CARTER	MARY		THOMPSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT
NO	N.A.	220-03-7641	FROSTBURG, MD 21532 PAUL E. COLEMAN, 83 BEALL ST.,

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Advanced Metastatic Breast Ca.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/2/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
Dr. Qamar Zaman	Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	12/5/85	FROSTBURG MEM PARK	FROSTBURG ALLEGANY MD

24 FUNERAL DIRECTOR [signature] ADDRESS 60 W. MAIN ST.
BOWERS FUNERAL HOME FROSTBURG

25a. DATE REC'D. BY REGISTRAR DEC 10 1985 25b. REGISTRAR'S SIGNATURE [signature]

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Three legible carbon copies are required. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be detached for use with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

352138

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 85 32801

1. DECEASED NAME (TYPE OR PRINT): FIRST MARY; MIDDLE LOU; LAST COLEMAN

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH 12 DAY 4 YEAR 19 85 — 2b. HOUR 8:00 P.M.

3. SEX: FEMALE — 4. RACE: WHITE — 5. DATE OF BIRTH: MONTH DAY YEAR 4/2/20 — 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 5 YEAR 19 85 — 2d. HOUR 11:00 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA — 7b. CITIZEN OF WHAT COUNTRY? U.S.A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ — 9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.

10. CITY OR TOWN OF DEATH: FROSTBURG — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FROSTBURG HEIGHTS APTS. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE — 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND — 13b. COUNTY: ALLEGANY — 13c. CITY OR TOWN: FROSTBURG — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 100 HONEYSUCKLE LANE

14. FATHER'S NAME: FIRST LEWIS; MIDDLE BRADY; LAST JOHNSTON

15. MOTHER'S MAIDEN NAME: FIRST GRACE; MIDDLE GLADYS; LAST SMITH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES): N.A.

16b. SOCIAL SECURITY NO.: 177-26-5896

17. INFORMANT: MARY ANN MINNICK, RT. 2, BOX 324 FROSTBURG, MD 21532

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Francisco Reyes M.D. — TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER — DATE SIGNED 12/5/85

EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes — ADDRESS 900 Seton Dr. Cumberland Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL — 23b. DATE 12/7/85 — 23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK — 23d. LOCATION CITY OR TOWN FROSTBURG COUNTY ALLEGANY MD

24. FUNERAL DIRECTOR Sowers Funeral Home — ADDRESS 60 W. MAIN ST. FROSTBURG — 25a. DATE REC'D. BY REGISTRAR DEC 10 — 25b. REGISTRAR'S SIGNATURE Julia Davidson Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN SPECIAL ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

352091

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32602

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other than the event, the medical examiner must be notified.

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ALFRED	MIDDLE: JOSEPH	LAST: COMER, SR.	2a. DATE OF DEATH MONTH DAY YEAR: December 9, 1985	2b. HOUR: 3:10 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 11, 1933	6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.	
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic-Western	12b. KIND OF BUSINESS OR INDUSTRY: Maryland R.R.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: West Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Ridgeley	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS / ZIP CODE: 117 Main Street / 26753
14. FATHER'S NAME FIRST: Emil	MIDDLE: B.	LAST: Comer	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: - LAST: Ross
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): --	(IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 235-52-5023	17. INFORMANT ADDRESS: Helen Comer - Address same as #13 above.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): G-I Bleeding
DUE TO, OR AS A CONSEQUENCE OF (b): Ca. of Lung
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 1-30 19 85 to 12-9 19 85 that (I) (we) last saw the deceased alive on 12-9 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED: 12/9/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Q. Zaman

22e. ADDRESS: Memorial Hospital medical Building Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12-12-85	23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland-Allegany Co.-MD.
24. FUNERAL DIRECTOR NAME / ADDRESS: George-Upchurch FUneral Home, P.A. 202 Greene Street-Cumberland, MD. 21502	25a. DATE REC'D. BY REGISTRAR: DEC 16 1985	25b. REGISTRAR'S SIGNATURE: [signature]	

BP 99999

353103

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32603

1. FOR STATE REGISTRAR — REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
John	E.	Crites	12 10 85	9:50 P M

3. SEX	4. RACE	5. DATE OF BIRTH Month Day Year	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	May 3, 1903	82 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
W. Va.	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland,	Lions Manor Nursing Home	Machanist	Rail Road

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES X NO ☐	424 Columbia St. 21502

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Allen		Crites	Rosa	F.	Zerk

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		705-12-2354	Eleanor Crites	Oldtown, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma of the lungs

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

C.O.P.D - Severe.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-18, 19 85, to 12-10, 19 85, that (I) (we) last saw the deceased alive on 12-9, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
V. A. Ranjithan	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
V. A. Ranjithan, M. D.	LMNH Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 13, 1985	Sunset Memorial P.	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
William G. Kight	Cumberland, MD	DEC 17 1985	Davidson-Pondelick

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before disposition.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filled within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Male White May 3, 1903 82

W. Va. USA

Cumberland, Machinist Nail Road

MD Allegany Cumberland X 424 Columbia St. 21502

Allen Crites Rosa F. Clerk

No Eleanor Crites Oldtown, MD

Burial Dec.13,1983 Sunset Memorial P.Cumberland Allegany MD

William G. Right Cumberland, MD

345161

85 32604

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
IRENE	CECELIA	CRITZMAN	December 5, 1985	2:03P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	February 28 1905	80 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	Memorial Hospital	Beautician	Hair Salon		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Cumberland, Md.

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cumberland	YES ☒ NO ☐	Rt. 3 Thurmel Drive 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
David	H.	Coffman	Mary	----	Gumm

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-32-3278	Wanda Mellon	Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Bronchogenic Carcinoma	?
DUE TO, OR AS A CONSEQUENCE OF (c)	Congestive Heart Failure	2-5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
—	—		

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTORY ☐ CAUSE OF DEATH (IF UNDER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/9/85 19___ to 12/5/85 19___ that (I) (we) last saw the deceased alive on 12/5/85 19___ and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/5/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Howard Diener	Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	12-7-85	Zion Memorial Park	Cumberalnd	Allegany	Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leasure-Stein Inc.	Cumberland, Maryland 21502 230 Baltimore Ave.	DEC 9 1985	[signature]

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

GEORGE UPCHURCH FUNERAL HOME
202 GREEN STREET
CUMBERLAND, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

85 32805

REG. NO. 344083

DECEASED NAME (TYPE OR PRINT): FIRST WILLIAM	MIDDLE LEROY	LAST DAILEY	2a. DATE OF DEATH: MONTH DAY YEAR DECEMBER 4, 1985		2b. HOUR 2:40P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: MONTH DAY YEAR February 6, 1914	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): WEst Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY		MD.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Chef-SS. Peter & Paul Cath. Ch.		12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cumberland	YES ☒ NO ☐	235 Paca Street / 21502

14. FATHER'S NAME: FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME: FIRST	MIDDLE	LAST
Earl		Dailey	Lucille		Edenhart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W.II	214 07 5136	Josephine Dailey	ADdress same as #13 above.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1-2 Hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes; CA of Lung

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/20 85 to 12/4 85, that (I) (we) last saw the deceased alive on 12/4 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Renato Espina MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/4/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RENATO ESPINA MD	907 SETON DRIVE, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
Burial	12-7-85	SS. Peter & Paul Cem.	Cumberland-ALlegany Co.-Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, Md. 21502	DEC 6 1985	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before any action is taken.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

364061

BOALS FUNERAL HOME
1 - FOR STATE REGISTRAR 111 CHURCH STREET WESTERNPORT, MD 21562

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32606

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: GERALDINE VICTOR DAWSON				2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 19, 1985	2b. HOUR: 3:00P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 2 MONTH 9 DAY 1919 YEAR		6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sew Rite	12b. KIND OF BUSINESS OR INDUSTRY: Sewing
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Westernport	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: Rt. 1 Box 11 21562	
14. FATHER'S NAME FIRST MIDDLE LAST: Benjamin H. Wilt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Violet Youst	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 212-38-6295	17. INFORMANT: Mr. Lutian Dawson	ADDRESS: Westernport, Md. 21562		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Inferior M.I.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): ASCVD - Diabetes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-9, 19 85, to 12-19, 19 85, that (I) (we) last saw the deceased alive on 12-19, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Uriel Velandia	DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 12-21-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): URIEL VELANDIA	22e. ADDRESS: 924 SETON DRIVE CUMBERLAND, MD 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/22/85	23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery	23d. LOCATION: Barton CITY OR TOWN Allegany COUNTY Md. STATE	
24. FUNERAL DIRECTOR NAME: Boals Funeral Service	ADDRESS: Westernport, Md. 21562	25a. DATE REC'D. BY REGISTRAR: DEC 26 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

352050

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32807

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes", Section 5-310 requires that the medical examiner shall be notified before any injury or other traumatic event, the medical examiner shall take charge of the case.

1. DECEASED NAME (TYPE OR PRINT) FIRST: PEARL	MIDDLE: A.	LAST: DELBUSSO	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 7, 1985
2b. HOUR: 10:30A. M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: August 15,1918	6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Baker-Ali Ghan Shrine	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: 697 Gephart Drive / 21502			
14. FATHER'S NAME FIRST: Thomas	MIDDLE: P.	LAST: Ansell	15. MOTHER'S MAIDEN NAME FIRST: Malinda / MIDDLE: - / LAST: Pirl
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 171-14-5831	17. INFORMANT ADDRESS: Dominic Del Busso - Address same as #13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Intractable Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic Cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Prostatism

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11-14, 19 85, to 12-7, 19 85, that (I) (we) last saw the deceased alive on 12-7, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 12-9-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. BARRERA	22e. ADDRESS: MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12-9-85	23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Meml. GArdens	23d. LOCATION CITY OR TOWN / COUNTY / STATE: LaVale-Allegany-Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502	25a. DATE REC'D. BY REGISTRAR: DEC 16 1985	25b. REGISTRAR'S SIGNATURE: [signature]	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

347004

ZIEGLER FUNERAL HOME
FOR 1 - STATE REGISTRAR
HYNDMAN, PA 15545

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32603

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
IRVIN	AMBROSE	DIEHL	12/02/ 1985	9:38 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	Caucasian	04/13/1917	68 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Machinist	Auto Supply

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
PA	Somerset	Meyersdale	YES ☐ NO ☒	Box 152, R D 4/ ~~15552~~ 99999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John	Frank	Diehl	Lula	Ann	Michaels

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	WWII	208091870	Dorothy L. Diehl, R D 4, Meyersdale, PA 15552

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). Diabetes, Old CVA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/3/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RENATO ESPINA MD	907 SETON DRIVE CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/6/85	Cooks Cemetery	RD, Hyndman, Somerset, PA

24. FUNERAL DIRECTOR ADDRESS	25. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler, Hyndman, PA 15545	DEC 9 1985	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-removal permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 99999

DHMH - 16 50M 4/83
(VRA 15, 4)

364013

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32609

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
EDMON	YOUNG	DILL	December 12, 1985	9:25 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
male	white	01-03-1909	76 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
WV	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	ret. engineer	railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Allegany	Cumberland	YES ☒ NO ☐	22 Utah Avenue/21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Ernest	O.	Dill	Rosa Belle	Sensabaugh	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	WW II	220-10-0687	Mrs. Margaret A. Schaefer-Frederick, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Chronic Obstructive Lung Disease. Transitional cell Ca of bladder

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-11, 1985, to 12-12, 1985, that (I) (we) last saw the deceased alive on 12-12 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-13-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Robustiano Barrera	Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-15-1985	Sunset Memorial Park	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 18 1985	

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

Field	Entry
1. DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST	SAMUEL Freeman DISHONG JR
2a. DATE OF DEATH — MONTH / DAY / YEAR	DECEMBER 5 1985
2b. HOUR	6:10 AM
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH — MONTH / DAY / YEAR	Sept. 15, 1921
6. AGE (IN YEARS LAST BIRTHDAY)	64 YRS
IF UNDER 1 YEAR — MONTHS / DAYS	
IF UNDER 24 HRS — HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	PA
7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Widowed
9. BALTIMORE CITY OR COUNTY OF DEATH	ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH	Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Manager
12b. KIND OF BUSINESS OR INDUSTRY	Automobile
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland
13b. COUNTY	Allegany
13c. CITY OR TOWN	Corriganville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	No
13e. STREET ADDRESS / ZIP CODE	P.O. Box 236 / 21524
14. FATHER'S NAME — FIRST / MIDDLE / LAST	Samuel F. Dishong, Sr
15. MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	Marie Duckworth
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes
(IF YES, GIVE WAR OR DATES)	WW II
16b. SOCIAL SECURITY NO.	215-12-2598
17. INFORMANT / ADDRESS	Mrs. Sandra Robertson-Leadville, Colo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

	Cause	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Respiratory Failure	2 WKS
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Obstructive Pulmonary Disease	10 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Jan 1976 to Dec 5 1985, that (I) (we) last saw the deceased alive on Dec 4 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] Richard Schmitt — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/5/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): RIGHARD SCHMITT , MD

22e. ADDRESS: 900 SETON DRIVE, ECUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION — CITY OR TOWN / COUNTY / STATE
Burial	Dec. 7, 1985	Rest Lawn Mem. Gardens	LaVale, Alleg., MD

24. FUNERAL DIRECTOR — NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr. LaVale, MD	DEC 9 1985	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP______

DHMH - 16 60M 7/84 (VRA 15, 4)

353059

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 85 32511

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	KNOWN ☑ ESTIMATED ☐	MONTH	DAY	YEAR	2b. HOUR		
	Linda	Carol	Ellifritz			12	11	19 85	9:45 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Female	White	Aug. 17 1951	34 YRS.						12	11	19 85	11:15 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
W. Va.	U. S. A		Allegany Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Luke	114 Mullan Ave. Luke, Md.	Key PunchOper.	Said Inc.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Allegany	Luke	YES ☒ NO ☐	114 Mullan Ave Luke Md. 21540

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Gerald Guy	Joan Seaber		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		218-62-6002	Fred Ellifritz Luke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Squamous cell Carcinoma of	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Larynx with metastasis.	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Francisco Reyes M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-11-85

EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes ADDRESS 900 Seton Dr. Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY STATE
Burial	12-14-85	Philos	Westernport	Allegany Md

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Boal Funeral Service Westernport Md.	DEC 16 1985	Julia Davidson Hendrix

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

006205

1 - FOR STATE REGISTRAR

DURST FUNERAL HOME
2 E. MAIN ST
FROSTBURG, MD 21532

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

S S 3 2 8 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MARIE	AGNES	FARRELL	DECEMBER 18, 1985	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JAN. 2, 1907	78 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	TEACHER	SCHOOL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	MT. SAVAGE	YES X NO ☐	# 3 C STREET, 21545

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ROBERT		BIRMINGHAM	FRANCES		TRIMBLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		217 28 9756	EDWARD J. FARRELL,	SAME AS 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest possible New MI & Malignant Cardiac Arrhythmia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Severe CAD & previous MI

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiovascular disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Type II diabetes controlled with diet

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/9, 19 83, to 12/18, 19 85, that (I) (we) last saw the deceased alive on 11/5, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	MD		12/21/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
V.R. FELIPA	925 BISHOP WALSH DR. CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	DEC. 21 '85	ST. PATRICK CEM.	MT. SAVAGE, MD.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, FROSTBURG, MD. 21532	DEC 31 1985	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and return. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

006122

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32813

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
RUSSELL	ALVIN	FLAKE	DECEMBER 22, 1985	9:16 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
male	white	01-30-1905	80 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USa		ALLEGANY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	retired	Brewing Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES [X] NO [ ]	1823 Frederick Street/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
William Flake	Lavainia Browning

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		218-16-2762	Mrs. Hazel P. Flake, Cumberland, MD - wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Acute MI

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) Cardiogenic Shock

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/22 19 85 to 12/22 19 85 that (I) (we) last saw the deceased alive on 12/22 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
J. William Flake	MD		12/24/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. WILLIAM P. IAMES	441 N. CENTRE STREET, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12-24-1985	Pleasant Grove Cem.	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 27 1985	Julia Davidson Rodgers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please see that both papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

347051

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32614

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before disposition.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
CHARLES	CLIFTON	FLETCHER	December 5, 1985	2:45 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	OCTOBER 12 1904	81 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	Memorial Hospital		RETIRED CELANESE	CORP. SILK	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	1818 FREDERICK STREET 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
COURTNEY	A.	FLETCHER	GRACE	ADAMS	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		217-10-1515	ETHEL FLETCHER	1818 FREDERICK ST CUMBERLAND MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory arrest	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Aspiration pneumonia	weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Dysphagia	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

CVA multiple recurrent

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-7- 19 85, to 12-5 19 85, that (I) (we) last saw the deceased alive on 12-4 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
A J Bollino	M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	12-5-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Anthony Bollino	955 Frederick Street Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	DEC 8 1985	SUNSET MEMORIAL PARK	CUMBERLAND ALLEGANY MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND	DEC 9 1985	Julia Davidson Registrar

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

365171

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32015

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Agnes	MARIE	Frankland	12	17	85	3:25 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	12	13	1896	89 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		Allegany County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Frostburg Community Hospital	HOUSE WIFE	-------

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	CUMBERLAND		811 SHRIVER AVE 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN	H.	BOETTNER	MARY	A.	WHITEFIELD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		214-16-2131	ANNA CURL	3200 NORTH EAST 36th ST FORT LAUDERDALE FLORIDA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) acute Hypovolemic Shock due to Gastro intestinal bleeding — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO, OR AS A CONSEQUENCE OF (b) multi Intestinal Obstruction

DUE TO, OR AS A CONSEQUENCE OF (c) due to Fecal impaction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Congestive heart failure / anemia / old age / Renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/9/ 19 85 to 12/17/ 19 85, that (I) (~~we~~) last saw the deceased alive on 12/16/85 19, and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
S Lal Sandhir	MD		12/17/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
S. Lal Sandhir, M.D	48 Tarn Terrace Frostburg, MD 21532

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	DEC 20 1985	HILLCREST BURIAL PARK	CUMBERLAND	ALLEGANY	MARYLAND

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL SERVICE	CUMBERLAND MARYLAND 21502	DEC 20 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remainder, Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other than natural cause, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

013095

1 - FOR STATE REGISTRAR

NEWMAN FUNERAL HOME
P.O. BOX 267
GRANTSVILLE, MD 21536

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32816

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ROSE	ANNA	GARLITZ	DECEMBER 29, 1985	8:10P M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	7/8/1911	74 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
PA	USA		ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Cook	Restaurant

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Garrett	Grantsville	YES ☐ NO ☒	Star Route, Box 150 21536

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Levi	--	Garlitz	Minnie	Mae	Klink

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	220-28-9885	Helen Edgar	Star Route, Box 150 Grantsville, MD 21536

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) metastatic carcinoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

Rheumatoid Arthritis.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒	MEDICAL DIRECTOR ☐	STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	M.D.				12-30-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SUSAN SCHWARTZ	FROSTBURG PLAZA, RTS. 36 & 40 FROSTBURG, MD 21532

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Jan. 2, 1986	St Ann's Cemetery	Avilton,	Garrett,	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
[signature]	Grantsville, MD	JAN 7 1986	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

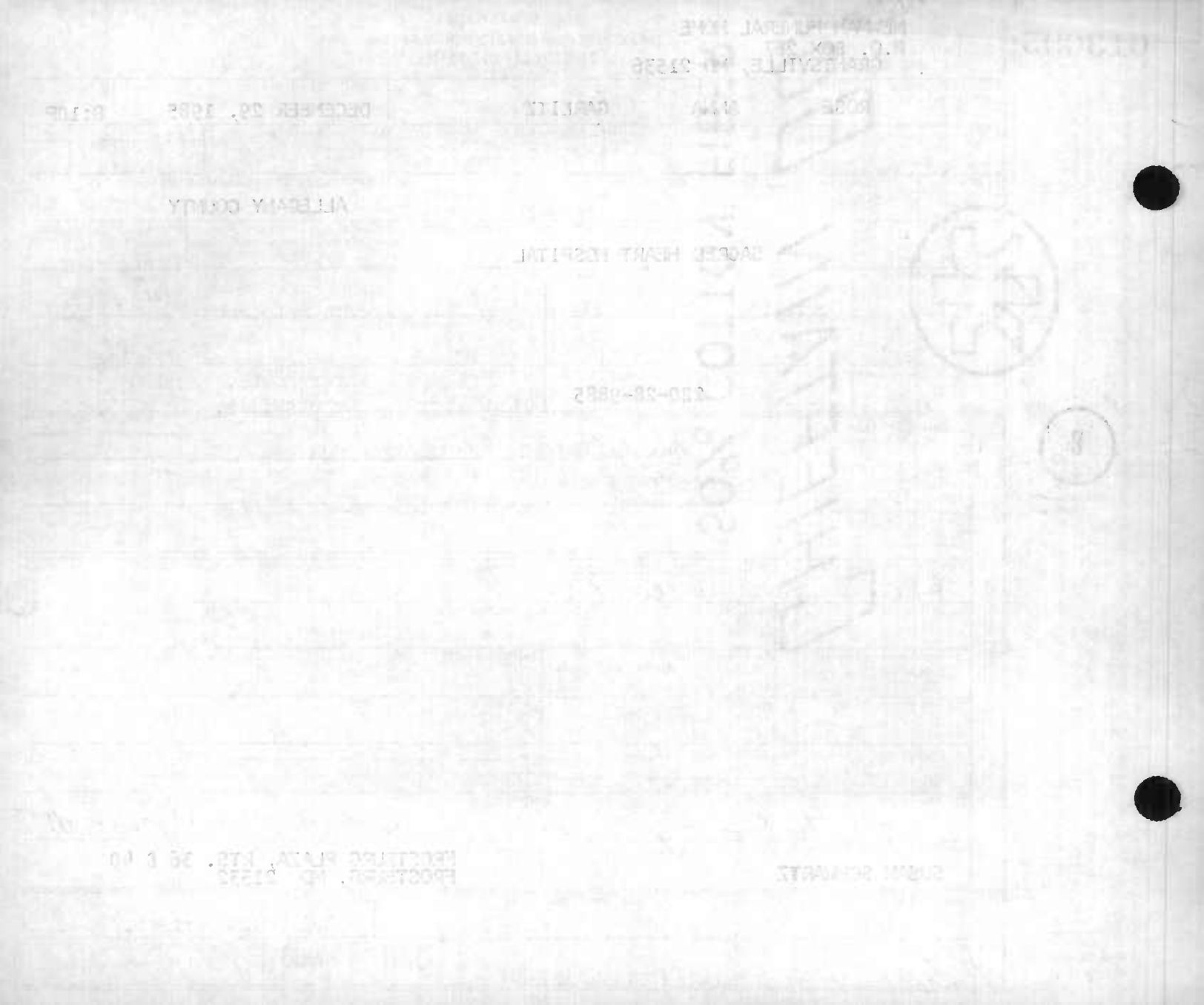
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic or medical cause, the medical examiner must be contacted prior to removal.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)



HOMBERT FUNERAL HOME

003003

1 - FOR STATE REGISTRAR — FOR BOX 37 CONFLUENCE PA, 15424

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32817

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
WILMA	LEATHERMAN	GEORGE	DECEMBER 28, 1985	9:25 A XXX M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	Nov. 23 1915	70 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Va.	U. S. A.		ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Housewife	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Pa.	Somerset	Addison	YES ☒ NO ☐	15411

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Frederick	H	Linkous	Margaret	B	Moore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		226-14-2672	Patricia Meyers	Addison Pa. 15411

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lung Cancer Metastatic to Brain — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) this hospital) attended the deceased from 12/20 19 85 to 12/28 19 85, that (I) (we) last saw the deceased alive on 12/28 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/28/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
RICHARD SCHMITT, MD	900 SETON DRIVE, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 31, 85	Addison Cemetery	Addison Somerset Pa.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Mark D. Thomas	CONFLUENCE, Pa.	JAN 2 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please review the cause(s) of death. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

008141

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 85 3 2 6 1 8

1. DECEASED NAME (TYPE OR PRINT) — FIRST: William MIDDLE: Irvin LAST: Gephart

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH 12 DAY 30 YEAR 19 85

2b. HOUR M

3. SEX: Male

4. RACE: Cau

5. DATE OF BIRTH — MONTH 7 DAY 1 YEAR 04

6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD — MONTH 12 DAY 30 YEAR 19 85

2d. HOUR 1630 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Lonaconing

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 36 Church Street

12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Ret. Sup. Gen.

12b. KIND OF BUSINESS OR INDUSTRY: Textile

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Lonaconing

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 36 Church Street 21635

14. FATHER'S NAME — FIRST: Harry MIDDLE: LAST: Gephart

15. MOTHER'S MAIDEN NAME — FIRST: Mary MIDDLE: LAST: Click

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): None

16b. SOCIAL SECURITY NO.: 216-07-2731

17. INFORMANT — ADDRESS: Mrs. Elizabeth Gephart 36 Church St. Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio-pulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

Conditians, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b): Left ventricular heart failure — months

DUE TO, OR AS A CONSEQUENCE OF

(c): Coronary artery heart disease — years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Gastric lymphoma

19a. DATE OF OPERATION: 12/21/85

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Gastric biopsy, lymphoma

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [XX], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Paul Snow M.D. — TITLE (SPECIFY) M.D. Dpty MEDICAL EXAMINER — DATE SIGNED 12/31/85

EXAMINER'S NAME (TYPE OR PRINT): Paul Snow, M.D. — ADDRESS: Memorial HOspital, Cumberland Md 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 1-1-86

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park

23d. LOCATION: Frostburg Allegany Md STATE

24. FUNERAL DIRECTOR (NAME AND ADDRESS): Richhorn Funeral Home, Lonaconing, Md.

25a. DATE REC'D. BY REGISTRAR: JAN 6 1986

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rondell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

364136

SCARPELLI FUNERAL HOME
VIRGINIA AVE.
CUMBERLAND, MD 21502

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32817

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JOHN	VERNON	GORDON	DECEMBER 11, 1985	2:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
male	white	02-08-1920	65 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	none	n/a

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	129 Offutt Street 21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Walter Gordon	Edith Clark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	none	Mr. William Kenneth Gordon, Cumberland, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septic Shock 2° Pseudomonas — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral pneumonia

DUE TO, OR AS A CONSEQUENCE OF (c) Possible Cerebral infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 12 1985 to Dec 12 1985 that (I) (we) last saw the deceased alive on Dec 12 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Chang Oh	MD		12/12/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CHANG OH	48 TARN TERRACE FROSTBURG, MD 21532

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12-13-1985	Davis Memorial Cem.	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 19 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

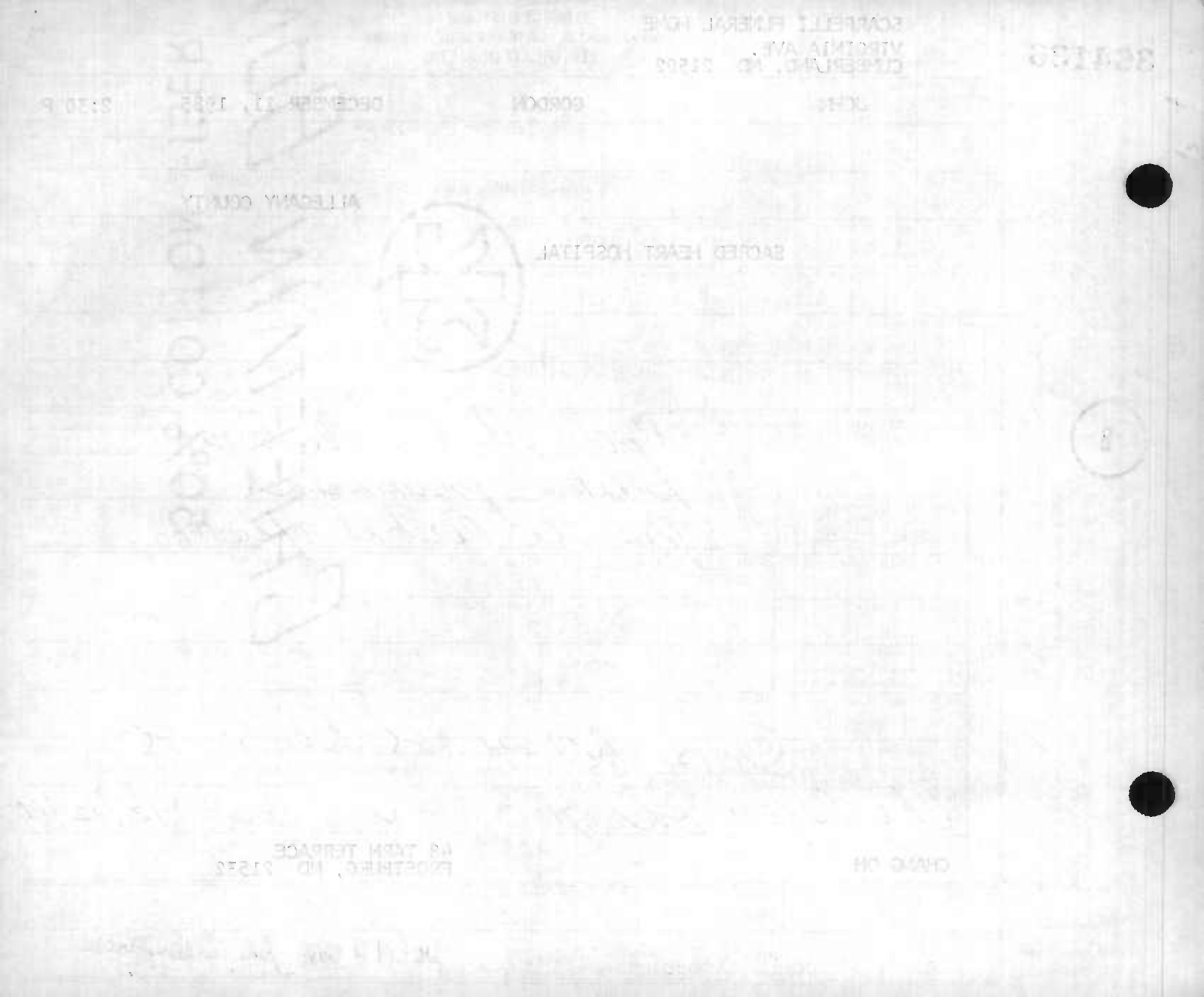
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to

BP

DHMH - 16 60M 7/84
(VRA 15, 4)



002175

MCKEE'S FUNERAL HOME
P.O. 124
AUGUSTA WVA 26704

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 85 32820

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN	MIDDLE: ALFRED	LAST: GROSS	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 18, 1985		2b. HOUR: 7:15 A
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Oct 7, 1909	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic		12b. KIND OF BUSINESS OR INDUSTRY: Automobile
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: W. Va.	13b. COUNTY: Hampshire	13c. CITY OR TOWN: Romney	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: Route 50 26757	
14. FATHER'S NAME FIRST: Thomas	MIDDLE	LAST: Gross	15. MOTHER'S MAIDEN NAME FIRST: Carrie	MIDDLE	LAST: Valentine
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 232-54-2667	17. INFORMANT: Johnny Gross	ADDRESS: Romney, W.Va. 26757		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William W Mark Jr MD	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 19 Dec 85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): WILLIAM MARK, MD	22e. ADDRESS: 925 BISHOP WALSH DRIVE, CUMBERLAND, MD. 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12/20/85	23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery	23d. LOCATION CITY OR TOWN: Romney	COUNTY: Hampshire STATE: W. Va.
24. FUNERAL DIRECTOR NAME: James R. Ryder	ADDRESS: Augusta, W.Va.	25a. DATE REC'D. BY REGISTRAR: DEC 31 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson Rogers	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP 999999

DHMH 1-16-80/M 7/84
(VRA 15.4)

008112

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32621
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST			2a. DATE OF DEATH MONTH / DAY / YEAR		2b. HOUR
Emma		Grunfelder	12	29 85	8:05 A. M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH / DAY / YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	01-04-1896	89 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Germany	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	Lions Manor Nursing Home		housewife	own home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	1312 Michigan Avenue/21502

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Joseph Uecker	Anna (nmn)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		097-05-5927	Mrs. Ella M. Lagratta, Cumberland, MD-daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebro vascular accident.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

C.H.F, A.S.H.D.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-3, 19 85, to 12-29, 19 85, that (I) (we) last saw the deceased alive on ____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
V. A. Ranjithan		12-30-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
V. A. Ranjithan, M. D.	L.M.N.H. Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-31-1985	St. Marys Cemetery	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	JAN 2 1986	Julia Davidson Rondelle

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remind the informant to call at the office of the local registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

364004

280

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32322

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver pages 1 and 2 to the local newspapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: CARLETON	MIDDLE: W	LAST: HANKS, JR	2a. DATE OF DEATH MONTH: DEC	DAY: 14	YEAR: 1985
2b. HOUR: 1220HRS M					
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: JUNE DAY: 06 YEAR: 1921	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.		
10. CITY OR TOWN OF DEATH: CUMBERLAND MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL AND MEDICAL CE	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ret. pharmacist	12b. KIND OF BUSINESS OR INDUSTRY: pharmacy		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 701 ARUNDEL STREET 21502	
14. FATHER'S NAME FIRST / MIDDLE / LAST: Carleton W. Hanks, Sr.		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Bessie A. Spiker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): yes	(IF YES, GIVE WAR OR DATES): WW II	16b. SOCIAL SECURITY NO.: 215 12 2251	17. INFORMANT ADDRESS: MEMORIAL HOSPITAL		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular fibrillation
DUE TO, OR AS A CONSEQUENCE OF (b): CAD.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 2/2 19 85, to 12/14 19 85, that (I) (we) last saw the deceased alive on 12/14 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Helmus	DEGREE: MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 12/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR PETER HALMOS	22e. ADDRESS: MEMORIAL MED BUILDING CUMB MD 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12-16-1985	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME / ADDRESS: James F. Scarpelli, Cumberland, MD 21502	25a. DATE REC'D BY REGISTRAR: DEC 18 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Pondelle	

315142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
85 32823

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST Jeannette MIDDLE Marie LAST Heagle

2a. DATE OF DEATH: KNOWN ☑ ESTIMATED ☐ MONTH 12 DAY 01 YEAR 85

2b. HOUR 08:37 A.M.

3. SEX: female

4. RACE: white

5. DATE OF BIRTH: MONTH 03 DAY 06 YEAR 1948

6. AGE (IN YEARS LAST BIRTHDAY): 37 YRS.

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 01 19 85

2d. HOUR 8:37 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): GERMANY

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSE WIFE

12b. KIND OF BUSINESS OR INDUSTRY: -------

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: CUMBERLAND

13d. INSIDE CITY LIMITS? YES ☐ NO XX

13e. STREET ADDRESS: 315 McGILL DRIVE 21502

14. FATHER'S NAME: FIRST UNKNOWN MIDDLE LAST BARTCZAK

15. MOTHER'S MAIDEN NAME: FIRST JADWIGA MIDDLE LAST BARTCZAK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 130409773

17. INFORMANT ADDRESS: MICHAEL HEAGLE 315 McGILL DRIVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Liver Cirrhosis, and possible

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): bleeding esophageal varies due to

DUE TO, OR AS A CONSEQUENCE OF (c): Chronic alcoholism. -

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO X

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Francisco Reyes M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 12-1-85

EXAMINER'S NAME (TYPE OR PRINT): Francisco Reyes ADDRESS: 900 Seton Dr. Cumberland, Md 21502.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: DEC 2 1985

23c. NAME OF CEMETERY OR CREMATORY: rosedale cremAtory

23d. LOCATION CITY OR TOWN: MARTINSBURG COUNTY: BERKELEY STATE: W.VA.

24. FUNERAL DIRECTOR NAME AND ADDRESS: SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.

25a. DATE REC'D. BY REGISTRAR: DEC 05 1985

25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN FIVE HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM FM 3. RETAIN, PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

003088

1 - FOR STATE REGISTRAR

GEORGE UPCHURCH FUNERAL HOME
GREENE STREET
CUMBERLAND, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32324

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
EDITH	FRANCES	HELKER	DECEMBER 28, 1985	10:30 M A

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Oct. 24, 1907	78 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	U.S.A.		ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Textile Dept-Amcelle	Celanese

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cumberland	YES XX NO ☐	316 Washington Street / 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Frederick	-	Murray	Hattie	-	Dix

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-	214-07-5657A	John Helker-Address same as #13 above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) GANGRENE OF BOWEL — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) MESENTERIC ARTERY OCCLUSION — 36 hrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec 27, 19 85, to Dec 28, 19 85, that (I) (we) last saw the deceased alive on Dec 28, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Paul Livengood MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-28-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Paul Livengood, M.D.	BMG 912 SETON DRIVE, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12-30-85	Hillcrest Burial Park	Cumberland-Allegany Co.-MD.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502	DEC 31 1985	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

364135

FOR STATE REGISTRAR

Scarpelli Funeral Home
108 Virginia Ave
Cumberland, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32825
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Foster	S.	Helmick	December 12, 1985	12:30A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
male	white	07-14-1910	75 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
WV	USa		Allegany County, MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	ret. engineer	railroad

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Allegany	Cumberland	YES ☒ NO ☐	1008 Oldtown Road/21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Sherwood	Helmick		Eva	Harper	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		232032405	Mrs. Bridget Spielman-Hagerstown, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	12 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Aspiration Pneumonitis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Parkinsons Disease. acute Urinary Tract Infection. Organic Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/4, 1985, to 12/12/85, 1985, that (I) (~~not~~) last saw the deceased alive on 12/11/85, 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
S Sandhir MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	12/12/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Sikander Sandhir, M.D.	48 Tarn Terrace, Frostburg, MD 21532

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-13-1985	Davis Memorial Cem.	Cumberland / Allegany / MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 19 1985	Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be accurately and completely filled in by the funeral director, page 3 retained by the hospital or attending physician. Page 4 may be detached and should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal from the state.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, the medical portion must be completed or the IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or the

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

353056

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32026

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the items on this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Elmer	DEWEY	Henderson	12-12-85	11:15am

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
male	WHITE	10 13 97	88 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
W.VA.	USA		Allegany Co. MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DONE FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Allegany County Nursing Home	RETIRED B&O RAILROAD TRAINMAN	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	901 Queen City Towers 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ROBERT	A.	HENDERSON	MINNIE		McBRIDE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		705-09-7899	LILBURN HENDERSON	BOX 35 GREENSPRING W.VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma - Metastatic of the lung

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): A.S.C.V.D. - Bilateral carotid disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-3, 19 84, to 12-12, 19 85, that (I) (we) last saw the deceased alive on 12-10-85, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
V.A. Ranjithan	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-12-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
VIMALA V. A. RANJITHAN.	906 Weires Ave., LaVale, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	DEC 14 1985	FOREST GLEN CEMETERY	GREENSPRING HAMPSHIRE W.VA.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL SERVICE	CUMBERLAND, MARYLAND	DEC 16 1985	Julia Davidson Registrar

BP____

DHMH - 16 50M 4/83
(VRA 15, 4)

365192

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32827

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
EMMA	JOSEPHINE	HERNDON	DECEMBER 19, 1985	10:35AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
female	white	05-16-1926	59 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
WV	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	housewife	own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Oldtown	YES ☐ NO ☒ XX	Route 1 Box 409/21555

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
William Clinton Knight	Anna Wickline

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		235-36-1040	Mrs. Arnett D. Herndon, Oldtown, MD - wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	1 day
DUE TO, OR AS A CONSEQUENCE OF (b)	Metastatic adenocarcinoma	6 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Pneumonia	10 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital) attended the deceased from 12-9, 19 85, to 12-19, 19 85, that (I) (we) last saw the deceased alive on 12-9, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
William Lamm	MD		12/19/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. LAMM	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12-22-1985	Oldtown Veterans Cem.	Oldtown Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 23 1985	Julia Davidson Register

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and forward pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

006148

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32028

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 with the body. Page 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
HOWARD	CLAY	HETRICK	December 19, 1985	2:50 p M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	2/10/1913	72 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	Memorial	Retired Construction Wker	Roads		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Garrett	Grantsville	YES [ ] NO [X]	Star Route, Box 35F 21536

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph	--	Hetrick	Arminta	--	Butler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	---	201-01-8086	Mrs. Ethel M. Hetrick Star Route, Box 35F Grantsville, MD 21536

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	Immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Pneumonia	Unknown
DUE TO, OR AS A CONSEQUENCE OF (c)	C.V.A. (Cerebral Vascular Accident)	"

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: N/A

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
N/A	N/A	YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from November, 19 1985, to Dec 19, 19 85, that (I) (we) last saw the deceased alive on Dec 19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	12/19/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Diener	500 Memorial Ave., Memorial MEd. Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / STATE
Burial	12/22/1985	Grantsville Cemetery	Grantsville, Garrett MD

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
A. Leon Newman	Grantsville, MD	DEC 20 1985	[signature]

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

315162

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32829

REG. NO.

1 FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	2b. HOUR
	THOMAS	Jackson J	HICKLE	December 6, 1985	2:00 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				MONTHS	DAYS	HOURS	MIN.
Male	White	May 28, 1901	84 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Railroad	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cumberland	YES ☒ NO ☐	15 S. Liberty St. 21502

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Thomas		Hickle	Amanda		Watts

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	705-10-5126	Mary K. Burris	7608 Lancaster Road Little Rock, Arkansas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxic encephalopathy

DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent seizures & Aspiration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Pneumonia Rt lung CAD Organic brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that I (this hospital) attended the deceased from 11/21/85, 19, to 12/6/85, 19, that I (we) last saw the deceased alive on 12/6/85, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Thomas A Nathan	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	12/6/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Nathan	Medical Building Memorial Hospital Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Removal	12/9/85	Cedar Hill Cemetery	Glen Burnie	Anne Arundel	Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leasure-Stein Funeral Home, Inc.	230 Baltimore Ave. Cumberland, MD 21502	DEC 9 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other outside event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

008007

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32830

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Nellie G. Hockman	2a. DATE OF DEATH MONTH DAY YEAR	12 27 85
		2b. HOUR	5:15 PM
3. SEX	Female	4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	Jan. 16, 1898	6. AGE (IN YEARS LAST BIRTHDAY)	87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Frostburg Village Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Retired	12b. KIND OF BUSINESS OR INDUSTRY	Practical Nurse
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Allegany
13c. CITY OR TOWN	Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS	114 South Smallwood St. 21502		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Elwood Crabtree	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Ida Platt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	214-05-5002	17. INFORMANT ADDRESS	Mr. Edwin L. Hockman, Annandale Va.-Son

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CHF, pacemaker insertion

DUE TO, OR AS A CONSEQUENCE OF (c) CVA - Rt. Hemiplegia, Aphasia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1979 to Dec 27, 1985, that (I) (we) last saw the deceased alive on Dec 20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Shin E. KIM MD DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shin E. KIM MD 22e. ADDRESS 90 main St. Westernport md 21562

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	12-30-1985
23c. NAME OF CEMETERY OR CREMATORY	Sulphur Springs Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE	Near Oldtown, Md.
24. FUNERAL DIRECTOR NAME / ADDRESS	James F. Scarpelli, Cumberland, Md. 21502	25a. DATE REC'D. BY REGISTRAR	JAN 6 1986
		25b. REGISTRAR'S SIGNATURE	

BP_____

DHMH-16 25M (VRA 15, 4) 1/79

006165

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32831
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Harold K Hollada			2a. DATE OF DEATH MONTH DAY YEAR	12/21/85
				2b. HOUR	12:10a M
3. SEX	male	4. RACE	white	5. DATE OF BIRTH MONTH DAY YEAR	1 23 30
6. AGE (IN YEARS LAST BIRTHDAY)	55 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany Co MD.				
10. CITY OR TOWN OF DEATH	Frostburg, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Frostburg Community Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md	13b. COUNTY	Garrett	13c. CITY OR TOWN	Grantsville
13d. INSIDE CITY LIMITS?	YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE	Star Rt 1, 21536		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Russell -- Hollada	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Mary -- Folk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	Yes	(IF YES, GIVE WAR OR DATES)	Korea	16b. SOCIAL SECURITY NO.	217 28 0250
17. INFORMANT	Miss Terry Hollada	ADDRESS	Route 1, Box 170 Meyersdale, PA 15552		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARRYTHMIAS

DUE TO, OR AS A CONSEQUENCE OF (c) THEOPHYLLINE Toxicity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

ARTERIOSCLEROTIC HEART DISEASE, CHRONIC OBSTRUCTIVE LUNG DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospitol) attended the deceased from 12/20, 19 85, to 12/21, 19 85, that (I) (we) last saw the deceased alive on 12/20, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	S. Chang	DEGREE	M.D
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐		22c. DATE SIGNED	12/21/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Dr. S. Chang	22e. ADDRESS	Hecks Plaza, Frostburg, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	12/23/~~18~~ 85	23c. NAME OF CEMETERY OR CREMATORY: Maple Glen Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Fort Hill, Somerset, PA			
24. FUNERAL DIRECTOR NAME	D. Lynn Dennison	ADDRESS	Grantsville, MD	25a. DATE REC'D. BY REGISTRAR: DEC 30 1985
25b. REGISTRAR'S SIGNATURE	Julia Faith Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the medical examiner's office, if he has jurisdiction of the case.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

350107

BOAL'S FUNERAL HOME

1 - FOR STATE REGISTRAR MAIN ST. Item 18a+b, 1-21-86 LONACONING, MD 21539

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32832
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
AMANDA	MAE	HUGHES	12/04/1985	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	03/31/1909	76 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Silk Mill	Material

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Lonaconing	YES ☒ NO ☐	21 Charlestown St. 21539

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Bruce		Coleman	Isabell		Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		213-24-7388	Mr. Frederick Hughes Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	2 hr
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary artery disease	2 year
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. DONALD MANGER	55 JACKSON ST. LONACONING, MD 21539

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/7/85	Laurel Hill Cemetery	Barton Allegany Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Boals Funeral Service	Lonaconing, Md. 21539	DEC 11 1985	Julia Davidson Rhodes

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and forward the certificate to the Division of Vital Records. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal from the state. Page 4 may be

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 1460

DHMH - 16 50M 4/83
(VRA 15, 4)

351073

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 85 5 3 2 8 3 3

1. DECEASED NAME (TYPE OR PRINT): First James; Middle —; Last Fitch Imes

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Month 12 Day 9 Year 1985 — 2b. HOUR 0900M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: Month 3 Day 24 Year 1908 — 6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YR. Months — Days — IF UNDER 24 HRS. Hours — Min. — 2c. DATE PRONOUNCED DEAD: Month 12 Day 9 Year 1985 — 2d. HOUR 1045A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.

10. CITY OR TOWN OF DEATH: Flintstone

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rt 1 Box 19 Flintstone

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Maintenance

12b. KIND OF BUSINESS OR INDUSTRY: Country Club

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Flintstone — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: Rt 1 Box 19 / 21530

14. FATHER'S NAME: First Albert; Middle —; Last Imes

15. MOTHER'S MAIDEN NAME: First Sadie; Middle —; Last Somerville

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 213-12-9142

17. INFORMANT ADDRESS: Leah Swick - Keyser, W. VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute congestive heart failure — minutes
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerotic heart disease — years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☒XX

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Dpty MEDICAL EXAMINER — DATE SIGNED 12-9-85

EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D. — ADDRESS Memorial Hospital, Cumberland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 12/12/85 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery — 23d. LOCATION CITY OR TOWN: Near Chaneysville — COUNTY, STATE: Bedford, PA

24. FUNERAL DIRECTOR NAME, ADDRESS: John J. Hafer, Jr. LaVale, MD

25a. DATE REC'D. BY REGISTRAR: DEC 13 1985 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PARTIES ... TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS ... RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE AND 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

Silcox

352152

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32834

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ERMA	MIDDLE: MAXINE	LAST: JOHNSON	2a. DATE OF DEATH MONTH DAY YEAR: December 5, 1985	2b. HOUR: 8:15 P.M.	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: FEB 1 1926	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RECPT. AND BOOKKEEPER	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☐ NO ☐: XX	13e. STREET ADDRESS / ZIP CODE: 1100 BEDFORD STREET 21502	
14. FATHER'S NAME FIRST: WILLIAM	MIDDLE: R. E.	LAST: SMITH	15. MOTHER'S MAIDEN NAME FIRST: HILDA	MIDDLE: R.	LAST: VALENTINE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 216-22-6430	17. INFORMANT ADDRESS: IRVIN JOHNSON 1100 BEDFORD ST CUMBERLAND MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Electrical dissociation	2 hr
DUE TO, OR AS A CONSEQUENCE OF (c)	Acute MI	1 day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO XX	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 12-5 19 85, to 12-5 19 85, that (I) (we) last saw the deceased alive on 12-5 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A. Bollino	DEGREE: M D	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12-6-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. A. Bollino	22e. ADDRESS: 955 Frederick Street Cumberland, MD 21502		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: DEC 8 1985	23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK	23d. LOCATION CITY OR TOWN / COUNTY / STATE: CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR NAME / ADDRESS: SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MARYLAND	25a. DATE REC'D. BY REGISTRAR: DEC 10 1985	25b. REGISTRAR'S SIGNATURE: [signature]		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

013106

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32835

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
ROBERT	LYNN	KARLOWA	December 30, 1985	10:00 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	JUNE 4 1952	33 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND	USA		Allegany MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	BURTONS MENS STORE --------	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	218 SCHLEY STREET 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
ROBERT	HENRY	KARLOWA	MARY		BURTON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		213-64-9136	ROBERT H. KARLOWA	218 SCHLEY STREET CUMBERLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Status epilepticus

DUE TO, OR AS A CONSEQUENCE OF (b) Blood A-V malformat

DUE TO, OR AS A CONSEQUENCE OF (c) Brain cranial bleed

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 12/24, 19 85, to 12/30, 19 85, that (I) (we) last saw the deceased alive on 12/30, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	1/1/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. William Iames	441 N. Centre Street Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	JAN 2 1986	ST MICHAELS CEMETERY	FROSTBURG ALLEGANY MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND	JAN 7 1986	Julia Davidson-Randall

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

353209

Boal Funeral Home
Westernport, MD 21562

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 85 32030

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b HOUR
Agnes	Louise	Kiddy	December 7, 1985	8:30p M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	4/ 25 1923	62 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Westernport	USA		Allegany County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	Med. Records	Hospital

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Garrett	Oakland	YES ☒ NO ☐	703 Mitchell Drive 21550

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	S	Dayton	Ethel	Green	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	WW11	219145834	Mrs. Glenda Newcomb Oakland, Md. 21550

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Brain Metastasis.
DUE TO, OR AS A CONSEQUENCE OF (b) Ca of breast - Mets.
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-12, 19 85, to 12-7, 19 85, that (I) (we) last saw the deceased alive on 12-7, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John Mehanna	M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-8-85

23d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Mehanna, M.D.	909-B Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Burial	10-11-85	Philos Cemetery	Westernport Allegany Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Boals Funeral Service Westernport, Md. 21562	DEC 13 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 4, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

008113

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32837

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
IRMA	M.	KLINE	Dec. 29, 1985	11:20 a M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
female	white	03-28-1916	69 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	former employee	textile

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	304 Grand Avenue/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Matthew Andrews	Daisy May George

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		214-07-6342	Mr. Maynard O. Kline, Cumberland, MD - husband

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebro Vascular Accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Acute Renal Failure Dialysis Dependent, Sepsis, Cellulitis of both legs, Diabetes.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
N. Rangithan	MD		12/29/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. R. Barrera	The Memorial Hospital Medical Building Memorial Ave., Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1-2-1986	Rose Hill Cemetery	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	JAN 2 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The page must accompany the cremation papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

353208

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32338

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	ELDEN / CLYDE / LANDIS	2a. DATE OF DEATH MONTH DAY YEAR	DECEMBER 7, 1985
2b. HOUR	1:50P M		
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	July 2, 1924	6. AGE (IN YEARS LAST BIRTHDAY)	61 YRS
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH	Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Machinist-Helper Chessie Sy.	12b. KIND OF BUSINESS OR INDUSTRY	R.R.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE	W.Va.	13b. COUNTY	Mineral
13c. CITY OR TOWN	Keyser	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS / ZIP CODE	333 St. Cloud St. 22676		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Clyde - Landis	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Anna - Friend
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	219-16-9694	17. INFORMANT ADDRESS	Lena E. Landis 333 St. Cloud St. Keyser, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Advanced Metastatic Ca.

DUE TO, OR AS A CONSEQUENCE OF (b) Primary unknown

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Q Zaman	DEGREE	MD
ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐		22c. DATE SIGNED	12/8/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	QAMAR ZAMAN	22e. ADDRESS	MEMORIAL MEDICAL BLDG. CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	10 Dec 1985	St. Thomas	Keyser	Mineral W. Va.
24. FUNERAL DIRECTOR NAME / ADDRESS	Allen Rotruck Keyser, W.Va.	25a. DATE REC'D. BY REGISTRAR	DEC 12 1985	25b. REGISTRAR'S SIGNATURE

347049

Film G612 Item 5 2/25/86 rla

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 32837

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH	DAY	YEAR	2b. HOUR
JOHN	JOSEPH	LAUGHLIN	12	1	19 85	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH	DAY	YEAR	2d. HOUR
Male	Cau	9/18/1918	67 YRS.			12	2	19 85	1847 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Westernport	402 Maryland Ave	Counselor	Education

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS
Maryland	Allegany	Westernport		402 Maryland Ave 21562

14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
John	A. Laughlin	Marie	Hohing
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW2	214-14-7881	Mrs. Barbara Beattie Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	sudden
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary artery heart disease	6 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Dpty MEDICAL EXAMINER DATE SIGNED 12/2/85

EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D. ADDRESS Memorial Hospital, Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/5/85	St. Peters Cemetery	Westernport Allegany Md.

24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Boals Funeral Service	Westernport, Md. 21562	DEC 2 1985	[signature]

07/84 25M BP____

DHMH - 17 (VR A15 ME (5))

x

364168

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32840

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be omitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filled within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified before the body is disposed of.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
DOROTHY	LOUISE	LEE	December 6, 1985	10:15 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	
Female	White	Aug 14 1924	61 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA		Allegany MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (KIND OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	Memorial Hospital		Housewife			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Pa	Somerset		YES ☐ NO X	RD3 Meyersdale 15552

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
George	W.	Taylor	Marie		Ryan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		200-14-7433	Harry F. Lee	RD 3 Meyersdale, Pa. 15552

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) HEPATIC COMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Lupoid Hepatitis.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Renal Failure Sicca Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Ranjithan DEGREE ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 12/9/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ranjithan

22e. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/9/85	Union Cemetery	Meyersdale Somerset Pa.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leckemby Funeral Home	M Ray Leckemby Meyersdale, Pa.	DEC 20 1985	Julia Davidson Rogers

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

352144

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32841
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
JOHN	GEORGE	LESTER, JR.	DECEMBER 7, 1985	3:20A M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
MALE	WHITE	JAN. 14 1910	75 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	USA		ALLEGANY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND	MEMORIAL HOSPITAL	RETIRED B & O RAILROAD				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	CUMBERLAND	YES XX NO ☐	208 POLK STREET 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN	G.	LESTER SR.	ELIZABETH		BEATTY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	WW11	705-05-1737	EVELYN LESTER 208 POLK ST CUMBERLAND MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) COPD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) CAP

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I **certify** that (I) (this hospital) attended the deceased from 11/20 19 85 to 12/7 19 85, that (I) (we) last saw the deceased alive on 12/6 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	12/7/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. WILLIAM P. IAMES	441 N. CENTRE ST. CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	DEC 9 1985	REST LAWN CEMETERY	LAVALE, ALLEGANY MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND	DEC 10 1985	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail the remainder of the certificate, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual circumstances, in the event the medical examiner has conducted a case

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

002176

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 85 32842

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chart, doctor's. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
LUCY	Virginia	LYONS	December 18, 1985	5:25 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	Oct. 28, 1908	77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia	U.S.A.		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	Memorial Hospital & Medical Center	Homemaker	Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
W.Va.	Grant	Maysville	YES ☐ NO ☒	Rt. #2 Box 62 99999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
John		Lyon	Lyda		Schell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		234-70-1310-A	Robert Lyon	Rt. #2 Box 62 Maysville, W.V

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac failure

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic heart disease

DUE TO, OR AS A CONSEQUENCE OF (c) generalized anteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Enlarged colon, Sore Lip

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐ ☒	12 11 1985	No history available

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	Home	Maysville, W.Va

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE, DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Robert Feddis MD		

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Robert Feddis	925 Seton Drive Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY
Burial	12/21/85	So. Branch Mem. Gar.	Petersburg, W.Va. 26847

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Arnold-Basagic Funeral Home Petersburg, W.Va.	DEC 31 1985	Julia Davidson-Rowe

99999 BP

DHMH - 16 60M 7/84
(VRA 15, 4)

365190

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32645

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SCOTT	MIDDLE:	LAST: MAC MILLAN	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 13 1985	2b. HOUR: 11:45 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: NOV. 14, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.	IF UNDER 24 HRS. HOURS:	MIN.:
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CUMBERLAND NURSING & CONVALESCENT CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): ENGINEERING	12b. KIND OF BUSINESS OR INDUSTRY: TEXTILE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 813 SHRIVER AVE, 21502	
14. FATHER'S NAME FIRST: ADAM	MIDDLE:	LAST: MACMILLAN	15. MOTHER'S MAIDEN NAME FIRST: MARTHA	MIDDLE:	LAST: LEE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES):		16b. SOCIAL SECURITY NO.: 214-07-1897	17. INFORMANT ADDRESS: AGNES SMITH, CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypoxia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): COPD.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE / ATTENDING PHYSICIAN ☐ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	22c. DATE SIGNED
P. Halmos	MD	12/14/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): P. HALMOS	22e. ADDRESS: 302 Schley St. Cumberland, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: DEC. 16, 1985	23c. NAME OF CEMETERY OR CREMATORY: OAK HILL CEMETERY	23d. LOCATION CITY OR TOWN: LONACONING, COUNTY: STATE: MD.
24. FUNERAL DIRECTOR NAME: DURST FUNERAL HOME, ADDR: FROSTBURG, MD.		25a. DATE REC'D. BY REGISTRAR: DEC 23 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

364025

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32044

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Margaret	Virginia	Markley	12	11	85	11:12am

3. SEX	4. RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
female	White	3	27	22	63 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Allegany Co. Nursing Home	Homemaker	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	Furnace St. Extd. 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Linburn	Smith	Blackburn	Mabel		Peyton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		234269720	Mr. Galen E. Markley	Short Gap, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Severe C.O.P.D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Cont - Pulmonale.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-17, 19 85, to 12-11, 19 85, that (I) (we) last saw the deceased alive on 12-11, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
V.A. Ranjithan		12-11-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
VIMALA A. RANJITHAN	906 Weires Ave., LaVale, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Dec. 14, 1985	Philos Cemetery	Westernport Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Markwood-McKenzie Funeral Home	111 S. Mineral Keyser, W.Va.	DEC 16 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

347048

HAFER FUNERAL HOME
NATIONAL HWY
LAVALE, MD 21502

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32845
REG. NO.

DIVISION OF VITAL RECORDS: 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	VIVIAN LUCILLE MATHENY		2a. DATE OF DEATH MONTH DAY YEAR	DECEMBER 5, 1985
			2b. HOUR	11:15AM
3. SEX	Female			
4. RACE	White			
5. DATE OF BIRTH MONTH / DAY / YEAR	03 / 27 / 1907			
6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	W. VA.			
7b. CITIZEN OF WHAT COUNTRY?	USA			
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]				
9. BALTIMORE CITY OR COUNTY OF DEATH	ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH	Cumberland			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife			
12b. KIND OF BUSINESS OR INDUSTRY	Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland			
13b. COUNTY	Allegany			
13c. CITY OR TOWN	Cumberland			
13d. INSIDE CITY LIMITS? YES [X] NO [ ]				
13e. STREET ADDRESS / ZIP CODE	609 Cumberland Arms/21502			
14. FATHER'S NAME FIRST / MIDDLE / LAST	Frederick Effinger			
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Adeline Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No			
(IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO.	220-34-1399			
17. INFORMANT ADDRESS	Ann Strieby - LaVale, MD			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Embolus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1hr

DUE TO, OR AS A CONSEQUENCE OF (b) AS HD, atrial fibrillation — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hiatus Hernia, renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE / DEGREE	George Breza MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 12/5/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	George Breza MD	22e. ADDRESS: BMG 912 SETON DRIVE, CUMBERLAND, MD 21502

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

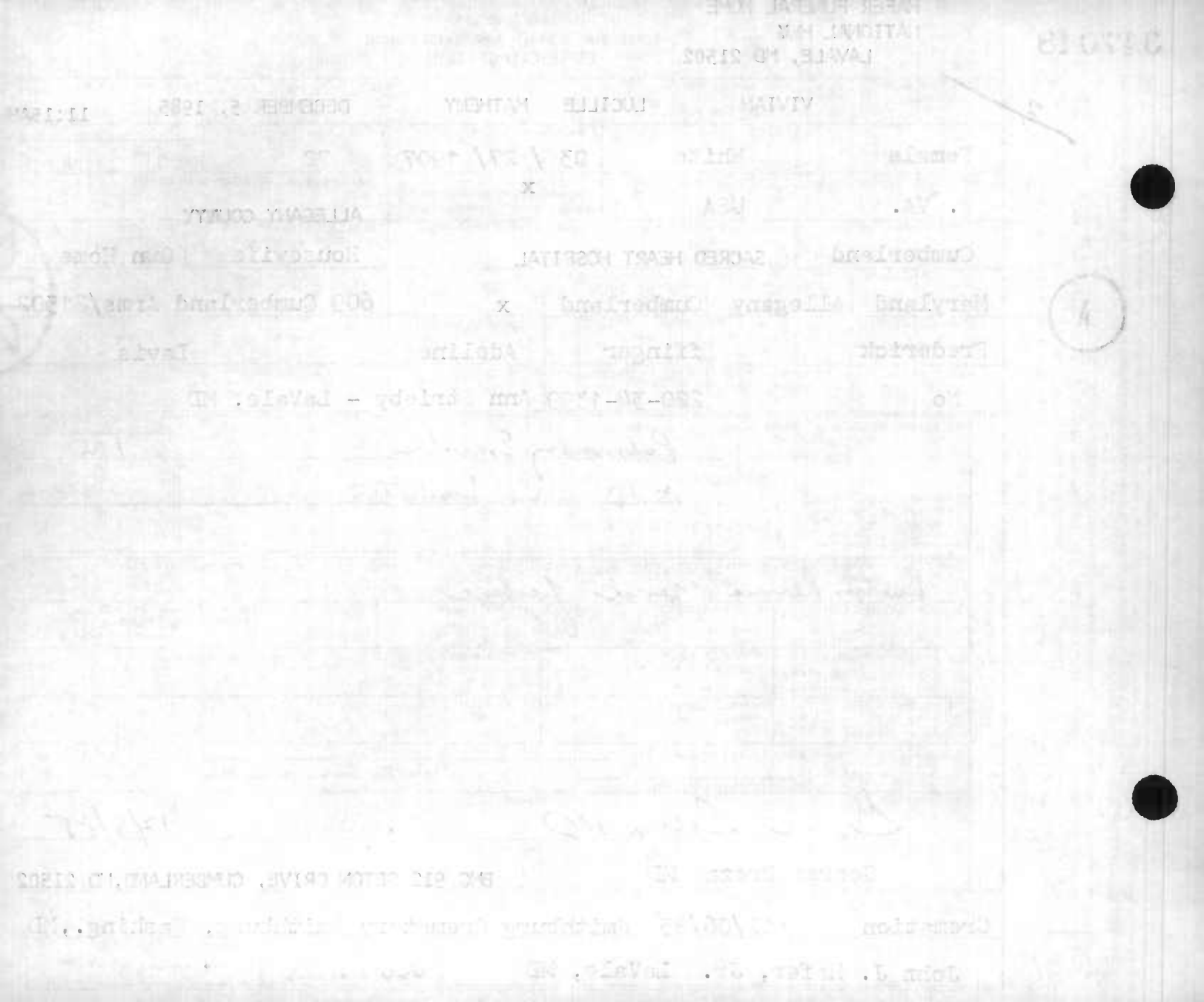
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Cremation	23b. DATE	12/06/85	
23c. NAME OF CEMETERY OR CREMATORY	Smithburg Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE	Smithburg, Washing., MD	
24. FUNERAL DIRECTOR NAME / ADDRESS	John J. Hafer, Jr. LaVale, MD	25a. DATE REC'D. BY REGISTRAR	DEC 11 1985	25b. REGISTRAR'S SIGNATURE

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)



008142

1 - FOR STATE REGISTRAR

George-Upchurch funeral Home
202 Greene Street
Cumberland, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32846
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Mary	Elizabeth	Mauk	December 30, 1985	10:40pm

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	OCtober 11,1926	59 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	U.S.A.		Allegany County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	HOmemaker	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
West Va.	Mineral	Ft. Ashby	YES XX NO ☐	Box 349 / 26719 99999

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	L.	Dowden	Frashier	-	Burkett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-	235822590	Phyllis Malone - WIley Ford, West Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cerebral hemorrhage	
DUE TO, OR AS A CONSEQUENCE OF (b)	Multiple myeloma w/ terminal stage	
DUE TO, OR AS A CONSEQUENCE OF (c)	Pneumonia, Severe	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-30 19 85, to 12-30- 19 85, that (I) (we) last saw the deceased alive on 12-30 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
John Mehanna	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-31-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
John Mehanna, M.D.	909-B Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	1-2-86	Ft. Ashby Cemetery	Ft. Ashby - Mineral - West Va.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryladn 21502	JAN 6 1986	

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 5 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

351115

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 85 32847

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RVR 1. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Robert	L.	McKenzie	2a. DATE OF DEATH KNOWN / ESTIMATED	☒ / ☐	12 / 10 / 85 (MONTH / DAY / YEAR)
2b. HOUR OF DEATH	1:50a M					
3. SEX	Male					
4. RACE	White					
5. DATE OF BIRTH (MONTH / DAY / YEAR)	Sept. 3, 1900					
6. AGE (IN YEARS LAST BIRTHDAY)	85 YRS.					
IF UNDER 1 YR. MONTHS / DAYS						
IF UNDER 24 HRS. HOURS / MIN.						
2c. DATE PRONOUNCED DEAD (MONTH / DAY / YEAR)	12 / 10 / 85					
2d. HOUR OF PRONOUNCED DEAD	1:50 a M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MD					
7b. CITIZEN OF WHAT COUNTRY?	USA					
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐						
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.					
10. CITY OR TOWN OF DEATH	Cumberland					
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Sacred Heart Hospital					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Custodian					
12b. KIND OF BUSINESS OR INDUSTRY	School					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md					
13b. COUNTY	Allegany					
13c. CITY OR TOWN	Frostburg					
13d. INSIDE CITY LIMITS? YES ☐ NO ☒						
13e. STREET ADDRESS	Rt 1, Box 454 21532					
14. FATHER'S NAME FIRST / MIDDLE / LAST	Leo	Wm.	McKenzie			
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Hanora		Coleman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	No					
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	None	212-12-8236				
17. INFORMANT ADDRESS	Mary Monroe Rt. 1, Box 454, Frostburg Md.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Giovanni Mastrangelo M.D. TITLE (SPECIFY) DEPU-4 MEDICAL EXAMINER DATE SIGNED 12/10/85

EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D. ADDRESS 900 Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 13, 1985	St. Josephs Cemetery	Midland / Allegany / Md

24. FUNERAL DIRECTOR AND ADDRESS Eichhorn Funeral Home, Lonaconing, Md. James E. McKenzie

25a. DATE REC'D. BY REGISTRAR DEC 13 1985

25b. REGISTRAR'S SIGNATURE and date

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

364098

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32848

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please [illegible] with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: ROY	MIDDLE: LELAND	LAST: MERRITT	2a. DATE OF DEATH MONTH DAY YEAR: December 13, 1985
2b. HOUR: 11:10p.M			
3. SEX: male	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: 03-13-1904	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired grocer	12b. KIND OF BUSINESS OR INDUSTRY: grocery store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	Valley Road-Forest Drive/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
William F. Merritt	Bessie E. Daniels

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		212-24-1296	Roy & Charles Merritt, Cumberland, MD - sons

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MYOCARDIAL FAILURE

DUE TO, OR AS A CONSEQUENCE OF (b): ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c): CONGESTIVE HEART FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It was) (did) (did not) [illegible] after death.

22b. SIGNATURE DEGREE	22c. DATE SIGNED
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

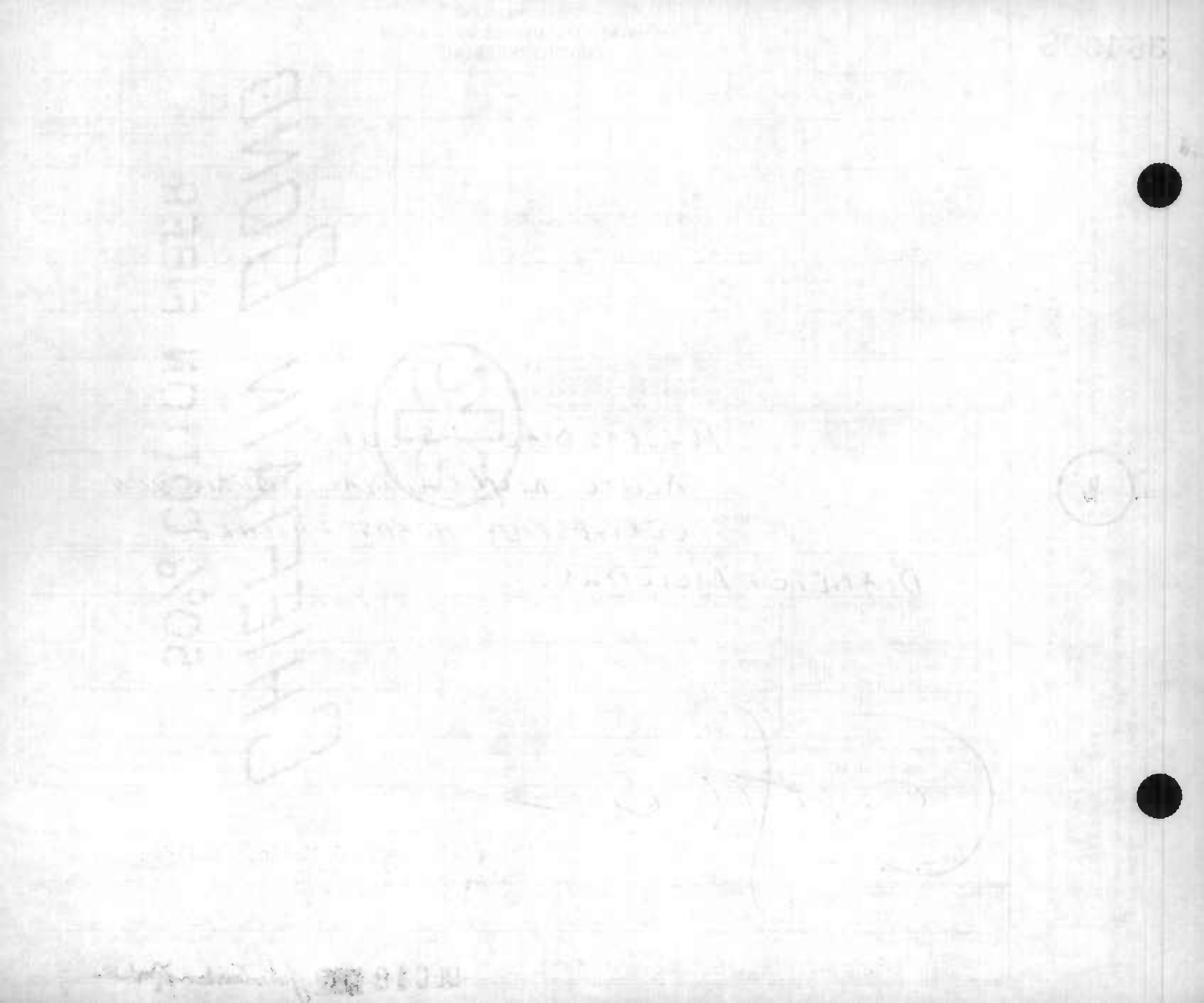
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. A. Torres	Memorial Hospital Medical Building Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-16-1985	St. Lukes Cemetery	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md 21502	DEC 18 [illegible]	[illegible]

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)



364166

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32847 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
TRUMAN	LESLEY	MICHAELS	DECEMBER 16, 1985	1:00A.M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS, DAYS	IF UNDER 24 HRS.: HOURS, MIN.
Male	White	1/12/1909	76 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND	MEMORIAL HOSPITAL	Sawmiller	Lumber		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Garrett	Friendsville	YES [ ] NO [X]	Route 1, Box 149 21531	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Victor	-	Michaels	Esta	-	VanSickle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
NO	---	215-18-9891	Mrs. Goldie P. Michaels	Route 1, Box 149 Friendsville, MD 21531	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) GRAM NEGATIVE SEPSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) LUL PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF (c) LYMPHOMA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

IMMUNE SUPPRESSION 2° TO #C

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] 22c. DATE SIGNED 10/16/85

23d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RAVER

22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/18/85	Sand Spring Cemetery	Friendsville, Garrett, MD

24. FUNERAL DIRECTOR (SIGNATURE) ADDRESS Grantsville, MD

25a. DATE REC'D BY REGISTRAR DEC 23 1985

25b. REGISTRAR'S SIGNATURE

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

353034

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32850

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Clarence E. Miller			2a. DATE OF DEATH MONTH DAY YEAR	December 11, 1985
				2b. HOUR	M
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	June 2, 1912
6. AGE (IN YEARS LAST BIRTHDAY)	73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.				
10. CITY OR TOWN OF DEATH	Frostburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	140 E. Main Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Pipefitter
12b. KIND OF BUSINESS OR INDUSTRY	Tire Co.				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Frostburg	YES [X] NO [ ]	140 E. MainSt., 21532

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
William T. Miller	Jessie Waddell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		214-07-5707A	Catherine Miller, Same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) metastatic carcinoma of the prostate — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Atherosclerotic cardiovascular Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED 12/12/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Schwartz, M.D. — 22e. ADDRESS Frostburg Plaza, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 14 '85	Eckhart Cemetery	Eckhart, Allegany, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Durst Funeral Home, Frostburg, Md.

25a. DATE REC'D. BY REGISTRAR: DEC 16 1985 — 25b. REGISTRAR'S SIGNATURE: [signature]

BP_____

DHMH - 16 60M 1/75
(VR A 15 (4))

013080

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32851

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Board's part. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified of case.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Edgar H Miller	2a. DATE OF DEATH MONTH DAY YEAR	12/28/85	2b. HOUR	9:02a M
3. SEX	maLe	4. RACE	white	5. DATE OF BIRTH MONTH DAY YEAR	8/02/ 11
6. AGE (IN YEARS LAST BIRTHDAY)	74 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.				
10. CITY OR TOWN OF DEATH	Frostburg, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Frostburg Community Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md	13b. COUNTY	Allegnay	13c. CITY OR TOWN	Frostburg
13d. INSIDE CITY LIMITS? YES [X] NO [ ]		13e. STREET ADDRESS / ZIP CODE	61 Broadway 21532		
14. FATHER'S NAME FIRST / MIDDLE / LAST	HARVEY MILLER	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	ALBERTA STEVENSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	N.A.	16b. SOCIAL SECURITY NO.	212 01 7498
17. INFORMANT (NAME) (ADDRESS)	MRS. EDGAR MILLER, 61 BROADWAY, FROSTBURG, MD 21532				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Inferio Wall Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Tan	22e. ADDRESS Frostburg Plaza, Frsotburg, Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
BURIAL	12/31/85	FROSTBURG MEM. PARK	FROSTBURG ALLEGANY MD	
24. FUNERAL DIRECTOR (NAME) (ADDRESS)	Sowers Funeral Home	60 W. MAIN ST. Main St., Frostburg, MD	25a. DATE REC'D. BY REGISTRAR JAN 9 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson-Rhodes

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

347002

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32852
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	MCCLELLAN HARRY MORGRET	2a. DATE OF DEATH MONTH DAY YEAR	12 05 85
		2b. HOUR	10:03A M
3. SEX	MALE	4. RACE	white
5. DATE OF BIRTH MONTH DAY YEAR	06 09 01	6. AGE (IN YEARS LAST BIRTHDAY)	84 YRS.
IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	PA	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Road Dept.	12b. KIND OF BUSINESS OR INDUSTRY	County
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	W. VIRGINIA	13b. COUNTY	Mineral
13c. CITY OR TOWN	RIDGELEY	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET ADDRESS / ZIP CODE	PO BOX 80 26753 99999		
14. FATHER'S NAME FIRST MIDDLE LAST	Alfred Morgret	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Bertha True
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	220-10-2212	17. INFORMANT ADDRESS	Mr. Paul A. Morgret, Ridgeley, WV - son

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) VENTRICULAR TACHYCARDIA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Vasculitis Hx of Anesth, CHF, Sepsis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Ranjithan	DEGREE M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED	12/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	DR. RANJITHAN	22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	12-08-1985
23c. NAME OF CEMETERY OR CREMATORY	Piney Plains Cemetery	23d. LOCATION CITY OR TOWN	Flintstone
COUNTY	Allegany	STATE	MD
24. FUNERAL DIRECTOR NAME ADDRESS	James F. Scarpelli, Cumberland, MD 21502	25a. DATE REC'D. BY REGISTRAR	DEC 9 1985
25b. REGISTRAR'S SIGNATURE	Julia Davidson Rogers		

999999 BP

DHMH / 16 60M 7/84
(VRA 15, 4)

360027

GEORGE UPCHURCH FUNERAL HOME
202 GREEN STREET
CUMBERLAND, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32853
REG. NO.

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 38 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: RUTH	MIDDLE: ELIZABETH	LAST: NINER	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 12, 1985
2b. HOUR: 9:50 AM			
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JUNE 18, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): COOK/CATERING	12b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: PINTO	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: RT. 6, NINER ROAD / 21556			
14. FATHER'S NAME FIRST: WRESSEL	MIDDLE	LAST: WINTER	15. MOTHER'S MAIDEN NAME FIRST: MARY
MIDDLE	LAST: GRABENSTEIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 215-42-4457	17. INFORMANT ADDRESS: JOHN H. NINER - ADDRESS SAME AS #13 ABOVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	myocardial infarction	1 hr
DUE TO, OR AS A CONSEQUENCE OF (b)	AS HD	5 years
DUE TO, OR AS A CONSEQUENCE OF (c)	CVA	3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

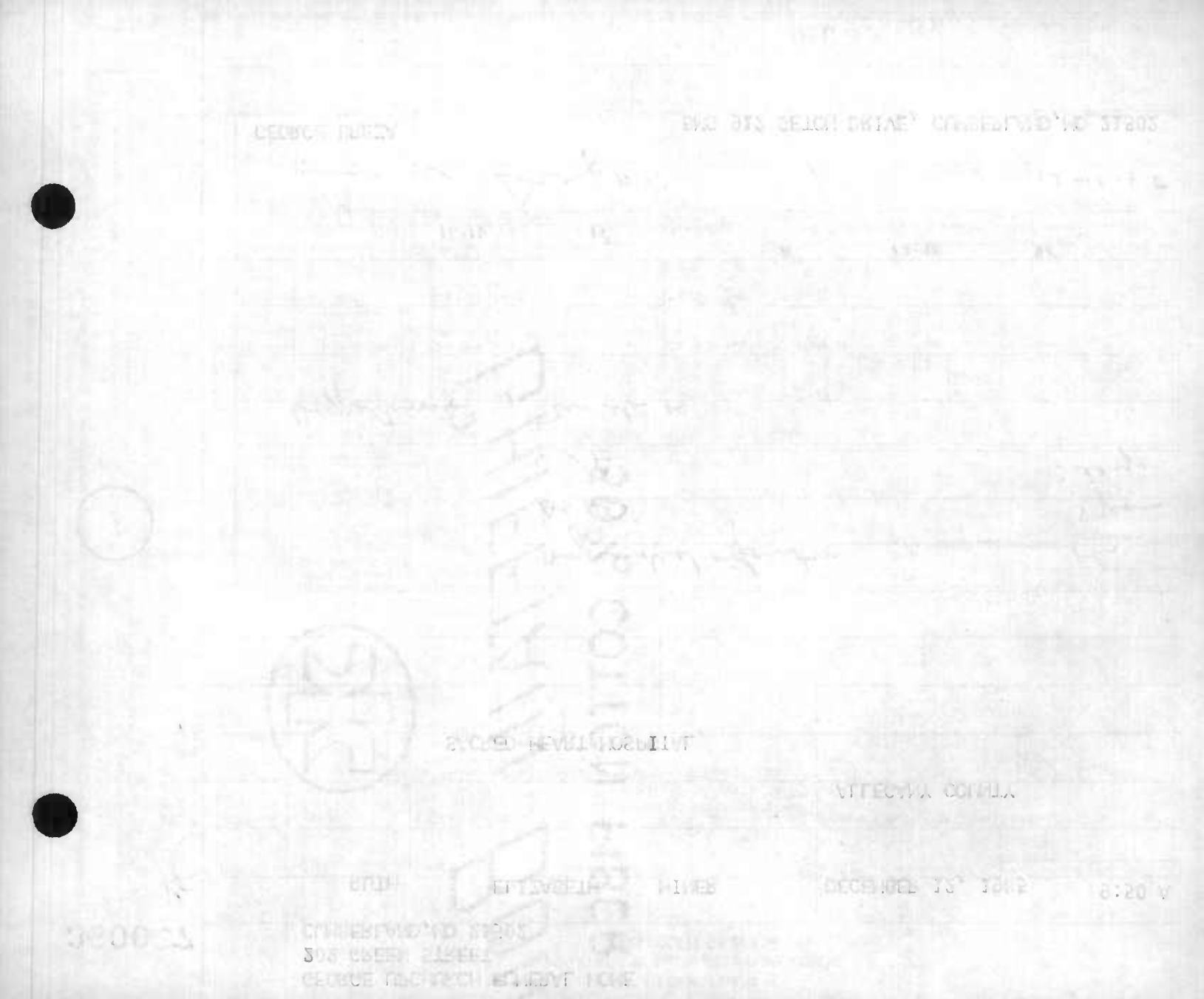
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 85, to 12-12, 19 85, that (I) (we) last saw the deceased alive on 12-12, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George Breza	DEGREE: MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 12-12-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): GEORGE BREZA	22e. ADDRESS: BMG 912 SETON DRIVE, CUMBERLAND, MD 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 12-16-85	23c. NAME OF CEMETERY OR CREMATORY: ST. AMBROSE CEMETERY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: CRESAPTOWN-ALLEGANY-MARYLAND
24. FUNERAL DIRECTOR NAME: GEORGE-UPCHURCH FUNERAL HOME, P.A.	202 GREENE STREET, CUMBERLAND, MARYLAND 21502	25a. DATE REC'D. BY REGISTRAR: DEC 23 1985	25b. REGISTRAR'S SIGNATURE: [signature]

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)



360025

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 3285 4

1. DECEASED NAME (TYPE OR PRINT): FIRST JAMES MIDDLE William LAST NORMAN

2a. DATE OF DEATH: KNOWN [XX] ESTIMATED [ ] MONTH 12 DAY 16 YEAR 85 19

2b. HOUR 1650 M

3. SEX: Male

4. RACE: Cau

5. DATE OF BIRTH: MONTH Jul DAY 3 YEAR 1909

6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 16 YEAR 85 19

2d. HOUR 1650 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. VA

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret Mechanic

12b. KIND OF BUSINESS OR INDUSTRY: AutoDealer

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cresaptown

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS: Boxx 5311 206 N. Bel Air Dr. 21502

14. FATHER'S NAME: FIRST Alonzo MIDDLE LAST Norman

15. MOTHER'S MAIDEN NAME: FIRST Jennie MIDDLE LAST Roberts

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 214-05-7284

17. INFORMANT: Ruth Norman ADDRESS: Cumberland, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrythemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Resolving myocardial infarction — 4 months

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary artery heart disease — years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Parkinsonism

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [XX], Inquiry [XX], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Paul Snow M.D. TITLE (SPECIFY): M.D. Dpty MEDICAL EXAMINER DATE SIGNED 12/16/85

EXAMINER'S NAME (TYPE OR PRINT): Paul Snow, M.D. ADDRESS: Memorial Hosp. Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec. 19, 1985

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial P

23d. LOCATION CITY OR TOWN Cumberland COUNTY Allegany STATE MD

24. FUNERAL DIRECTOR NAME: William G. Kight ADDRESS: Cumberland, MD

25a. DATE REC'D. BY REGISTRAR: DEC 23 1985

25b. REGISTRAR'S SIGNATURE: [illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

William

Jul 3, 1909

N. VA USA

Ret Mechanic Autodealer

x 206 N. Bel Air Dr. 21502

Alonzo Norman Jennie Roberts

No 214-05-7284 Ruth Norman Cumberland, MD

Burial Dec.19,1985:Hillcrest Burial P. Cumberland Allegany MD

William G. Right Cumberland, MD

0061777

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32855

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 2. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 3 must be filed within 5 days.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, coroner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST: RUTH	MIDDLE: ISER	LAST: OATES	2a. DATE OF DEATH MONTH: 12 DAY: 23 YEAR: 85	2b. HOUR: 2137 M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: 06 DAY: 11 YEAR: 1900	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): ALLEGANY	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY CUMBERLAND MD.		
10. CITY OR TOWN OF DEATH: CUMBERLAND MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIALHOSPITAL CUMBERLAND MD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED SCHOOL TEACHER	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: QUEEN CITY TOWERS PACA STREET 21502	
14. FATHER'S NAME FIRST: I. MIDDLE: W. LAST: ISER		15. MOTHER'S MAIDEN NAME FIRST: CATHERINE MIDDLE: LAST: FAULK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219-14-7028	17. INFORMANT: RICHARD HILL	ADDRESS: 4062 OLD ORCHARD ROAD YORK PA.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Pulmonary Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Penetrating ulcer of Stomach

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/24/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. V. RANJITHAN

22e. ADDRESS: MEMORIAL HOSPITAL CUMBERLAND MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: DEC 26 1985	23c. NAME OF CEMETERY OR CREMATORY: QUEENS POINT CEMETERY	23d. LOCATION CITY OR TOWN: KEYSER COUNTY: MINERAL STATE: WEST VIRGINIA	
24. FUNERAL DIRECTOR NAME: SILCOX-MERRITT	ADDRESS: DECATUR ST CUMBERLAND MD	25a. DATE REC'D. BY REGISTRAR: DEC 30 1985	25b. REGISTRAR'S SIGNATURE: [signature]	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 85 32856

006170

1. DECEASED NAME (TYPE OR PRINT): FIRST ARNOLD MIDDLE EMORY LAST OSTER
2a. DATE OF DEATH: MONTH DECEMBER DAY 26 YEAR 1985
2b. HOUR 1615 M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: MONTH 01 DAY 01 YEAR 05
6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY CUMBERLAND MD.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): ALLEGANY COUNTY NURSING HOME
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): machine operator
12b. KIND OF BUSINESS OR INDUSTRY: macaroni factor

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: Route 4 Oldtown Road/21502

14. FATHER'S NAME: FIRST Charles MIDDLE LAST Oster
15. MOTHER'S MAIDEN NAME: FIRST Anna MIDDLE L. LAST Boor
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 213-64-9828
17. INFORMANT ADDRESS: Mr. Clayton B. Oster Jr., Cumberland, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of prostate
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary Artery Disease, Atrial fibrillation, Zygomycosis Horner Syndrome

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
DEGREE: MD
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED 12/27/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. V. P. RANJITHAN
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-28-1985
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION CITY OR TOWN: Cumberland COUNTY: Allegany STATE: MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: James F. Scarpelli, Cumberland, MD 21502
25a. DATE REC'D. BY REGISTRAR: DEC 30 1985
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all boxes from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

364128

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 3285 7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 (PAGE 1). PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST: DOROTHY	MIDDLE: LENORA	LAST: OSTER	2a. DATE OF DEATH: KNOWN XX / ESTIMATED ☐ MONTH 12 DAY 16 YEAR 19 85	2b. HOUR 0755 M	
3. SEX: Female	4. RACE: Cau	5. DATE OF BIRTH: MONTH 9 DAY 5 YEAR 15	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 16 YEAR 19 85	2d. HOUR 0755 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Rt 4 Box 35 Oldtown Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired	12b. KIND OF BUSINESS OR INDUSTRY: Blouse Co.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Allegny	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Rt 4 Box 35 Oldtown Road 21502	
14. FATHER'S NAME FIRST: Charles	MIDDLE	LAST: Oster	15. MOTHER'S MAIDEN NAME FIRST: Anna	MIDDLE: L.	LAST: Boor
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 214-07-1177	17. INFORMANT ADDRESS: Mr. Clayton Oster, Cumberland, MD-brother			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma, left breast with metastasis

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypertension; Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry XXX and in my opinion death resulted from: Noturol couses XX Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐,

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Dpty MEDICAL EXAMINER DATE SIGNED 12/16/85

EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D. ADDRESS Memorial Hospital, Cumberland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12-18-1985	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION CITY OR TOWN: Cumberland COUNTY: Allegany STATE: Md	
24. FUNERAL DIRECTOR NAME / ADDRESS: James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR: DEC 19 1985	25b. REGISTRAR'S SIGNATURE: [signature]	

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

360024

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32358

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: Charles Robert Patrick		2a. DATE OF DEATH MONTH DAY YEAR: December 17, 1985	2b. HOUR: 4:35 P.M.
3. SEX: Male	4. RACE: Cau.	5. DATE OF BIRTH MONTH DAY YEAR: April 15, 1908	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: Luke	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 411 Pratt Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Administrator	12b. KIND OF BUSINESS OR INDUSTRY: Paper Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Luke	YES ☒ NO ☐	411 Pratt Street 21540

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Marcus Anderson Patrick	Jessie Grayson	Yes	WW II	216-07-9359	Beverly R. Jackson 115 Watson St. Thomasville Ga. 31792

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from ——— 19 Dec 14 to Dec 17 19 85, that (I) (we) last saw the deceased alive on 12/14 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert W. Bess MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/18/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Robert W. Bess, Jr., M D	Ashfield Street, Piedmont, W.Va. 26750

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Dec. 20, 1985	Philos Cemetery	Westernport, Alleg., Maryland

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Fredlock Funeral Home, Piedmont, W.Va. 26750	DEC 23 1985	Marian Davidson-Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on from 18 sho... any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1/73
(VR A 15 (4))

365070

1 - FOR STATE REGISTRAR: CHAPEL OF THE HILLS, 1302 NATIONAL HWY, LAVALE, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32057 — REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: JOHN THOMAS POLANDE	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 24, 1985	2b. HOUR: M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 8, 1903	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Textile

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cresaptown	YES [X] NO [ ]	12810 Knobley View Dr. 21502

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST		
Howard Poland	Ella Minerva Allen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No	217 10 4087	Vallie V. Poland - same as above	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarct

DUE TO, OR AS A CONSEQUENCE OF (b): C.A.D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12-24, 19 85, to 12-24, 19 85, that (I) (we) last saw the deceased alive on 12-24, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Uriel Velandia MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): URIEL VELANDIA M.D.	22e. ADDRESS: 924 SETON DRIVE CUMBERLAND, MD 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 28, 1985	Hillcrest Burial	Cumberland, Alleg., MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr. LaVale, MD 21502	DEC 27 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

008086

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32660

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: RUTH	MIDDLE: B.	LAST: RAY	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 28, 1985	2b. HOUR: 4:30 A.M	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: 01-28-1908	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CUMBERLAND NURSING & CONVALESCENT CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): housewife	12b. KIND OF BUSINESS OR INDUSTRY: own home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: PA	13b. COUNTY: Bedford	13c. CITY OR TOWN: Clearville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: Route 3 Box 325/15535	
14. FATHER'S NAME FIRST: Morris	MIDDLE: Baron	LAST	15. MOTHER'S MAIDEN NAME FIRST: Reine	MIDDLE: Weiner	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 085-32-0959	17. INFORMANT ADDRESS: Mrs. Elizabeth Weisman-Clearville, PA-sister			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Dysphonia.

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditians, if any, which gove rise to immediote cause (a), stoting the underlying couse lost.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHF

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from Dec. 19 84, to 12/28 19 85 that (I) (we) last saw the deceased alive on 12/26 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Halmos	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12/28/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): P. HALMOS MD	22e. ADDRESS: 302 Schley St. Cumberland		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please review copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12-31-1985	23c. NAME OF CEMETERY OR CREMATORY: Arlington Natl' Cem.	23d. LOCATION CITY OR TOWN: Arlington	COUNTY: Arlington STATE: VA
24. FUNERAL DIRECTOR NAME / ADDRESS: James F. Scarpelli, Cumberland, MD 21502	25a. DATE REC'D. BY REGISTRAR: JAN 2 1986	25b. REGISTRAR'S SIGNATURE: [signature]		

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

007097

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 3286
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	Emily	MIDDLE Marie M.	LAST Reissig	2a. DATE OF DEATH MONTH DAY YEAR	12 28 85
2b. HOUR	10:45 A.M.				
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	Sept. 21, 1894
6. AGE (IN YEARS LAST BIRTHDAY)	91 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.				
10. CITY OR TOWN OF DEATH	Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Lions Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Maryland	13b. COUNTY	Allegany	13c. CITY OR TOWN	Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET ADDRESS / ZIP CODE	614 Shriver Ave. 21502		
14. FATHER'S NAME FIRST	Edward	MIDDLE A.	LAST Clark	15. MOTHER'S MAIDEN NAME FIRST	Emma
MIDDLE		LAST	Rossworm		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	---	16b. SOCIAL SECURITY NO.	214-05-8268
17. INFORMANT	Thomas P. Shaffer	ADDRESS	528 Cumberland St. Cumberland, MD		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Advanced ASCVD, Senility.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from 6-6 19 80 to 12-28 19 85 that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	V. A. Ranjithan	DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 12-30-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	V. A. Ranjithan, M. D.	22e. ADDRESS	L.M.N.H. Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY STATE
Burial	12/31/85	SS Peter & Paul	Cumberland	Allegany MD

24. FUNERAL DIRECTOR NAME	Leasure-Stein Funeral Home, Inc.	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
ADDRESS	230 Baltimore Ave. Cumberland, MD 21502	JAN 3 1986	Julia Davidson-Rinehart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

010122

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32662

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: SHIRLEY	MIDDLE: ANN	LAST: RIDGELEY	2a. DATE OF DEATH MONTH DAY YEAR: December 31, 1985	2b. HOUR: 1:55 P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: May 25, 1941	6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY:		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cumberland	YES ☒ NO ☐	225 Oak Street 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Patrick	O.	Myers	Margaret		Cunrod

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	220-38-0221	Merritt A. Ridgeley	same as 13a-e.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bacterial endocarditis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
13 Dec 85	Peripheral embolus	YES ☒ NO ☐	YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 13 Dec, 19 85, to 31 Dec, 19 85, that (I) (we) last saw the deceased alive on 31 Dec 19 85 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Fred W. Miltenberger	M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	5 Jan 86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. F.W. Miltenberger	122 S. Centre St. Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/3/86	Restlawn Memorial	LaVale Allegany Maryland

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leasure-Stein Funeral Home, Inc.	230 Baltimore Ave. Cumberland, MD 21502	JAN 8 1986	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

353058

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 32863

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Roy — MIDDLE: Freeman — LAST: Ritchie, Jr.

2a. DATE OF DEATH — KNOWN XX / ESTIMATED ☐ — 12-9 19 85
2b. HOUR — M

3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 9/14/41
6. AGE (IN YEARS LAST BIRTHDAY): 44 YRS.
IF UNDER 1 YR. — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.
2c. DATE PRONOUNCED DEAD: 12-9 19 85
2d. HOUR: 10:50 a. M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED X / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany County, MD.

10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital - DOA
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SUPV.
12b. KIND OF BUSINESS OR INDUSTRY: CELANESE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: FROSTBURG
13d. INSIDE CITY LIMITS? YES X NO ☐
13e. STREET ADDRESS: 126 WASHINGTON ST. 21532

14. FATHER'S NAME — FIRST: ROY — MIDDLE — LAST: RITCHIE
15. MOTHER'S MAIDEN NAME — FIRST: ELEANOR — MIDDLE — LAST: YANTZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): YES
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 218-40-3145
17. INFORMANT — ADDRESS: MRS. ROY RITCHIE, JR., 126 WASHINGTON ST., FROSTBURG, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES X NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: [signature]
TITLE (SPECIFY): Assistant MEDICAL EXAMINER
DATE SIGNED: 12-10-85

EXAMINER'S NAME (TYPE OR PRINT): Dennis F. Smyth, M.D.
ADDRESS: 111 Penn St., Balto., Md. 21201

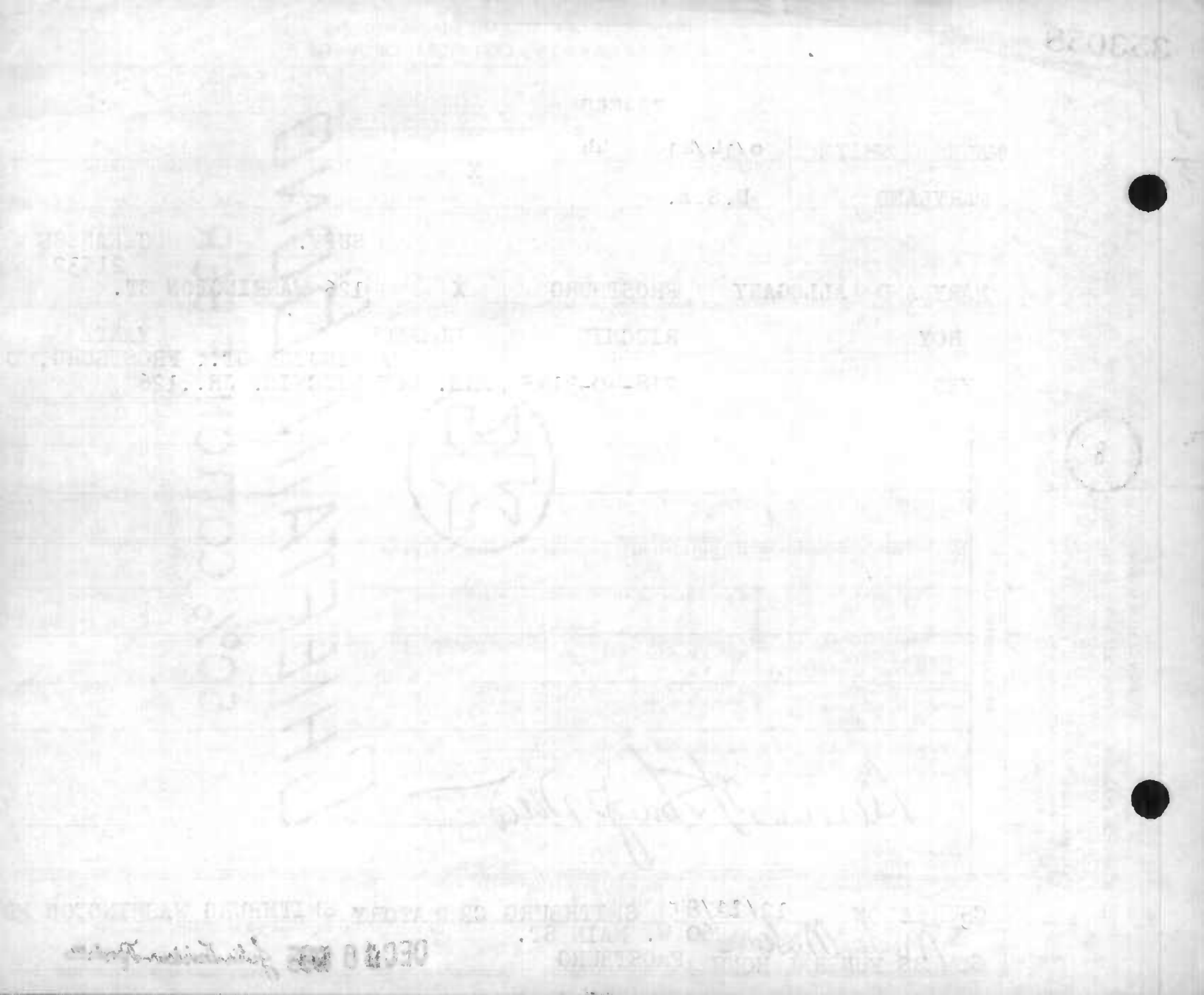
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION
23b. DATE: 12/11/85
23c. NAME OF CEMETERY OR CREMATORY: SMITHBURG CREMATORY
23d. LOCATION — CITY OR TOWN: SMITHBURG — COUNTY: WASHINGTON — STATE: MD

24. FUNERAL DIRECTOR — NAME: [signature] SOWERS FUNERAL HOME — ADDRESS: 60 W. MAIN ST. FROSTBURG
25a. DATE REC'D. BY REGISTRAR: DEC 16 1985
25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

07/84 25M
BP
DHMH - 17 (VR A15 ME (5))



352060

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32054

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours. The death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	FLORENCE I ROBINETTE	2a. DATE OF DEATH MONTH DAY YEAR	DECEMBER 9, 1985
		2b. HOUR	1:35P.M.
3. SEX	Female	4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	Oct. 4, 1905	6. AGE (IN YEARS LAST BIRTHDAY)	80 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	MD	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒		9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Sales Clerk	12b. KIND OF BUSINESS OR INDUSTRY	Liquor Store
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD	13b. COUNTY	Allrgany
13c. CITY OR TOWN	Corriganville	13d. INSIDE CITY LIMITS?	NO ☒
13e. STREET ADDRESS / ZIP CODE	Fords Crossing 21524		
14. FATHER'S NAME FIRST / MIDDLE / LAST	Charles Robinette	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Bessie Mae Kline
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	214-05-6039	17. INFORMANT ADDRESS	Duane Robinette , Artemas, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardio - respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c) COPD, UTI

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	MD	DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED 12/9/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	DR. ZAMAN	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	Dec.12,1985	Hillcrest Burial	Cumberland	Allegany MD
24. FUNERAL DIRECTOR NAME / ADDRESS	William G. Kight Cumberland, MD	25a. DATE REC'D. BY REGISTRAR	DEC 16 1985	25b. REGISTRAR'S SIGNATURE

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Female	White	Oct. 4, 1905	80		
MD	USA		x	Allegany	
				Sales Clerk	Liquor Store
MD	Allegany	Corriganville	x	Forde Crossing	21524
Charles	Robinette	Bessie	Mae	Kline	
No		Duane Robinette , Artemas, PA.			

Burial Dec.12,1985 Hillcrest Burial Cumberland Allegany MD

William G. Kight Cumberland, MD

365214

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32865 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JOHN	CHARLES	RODENHAUSER	December 19, 1985	3:50 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
male	white	01-25-1905	80 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	ret. Shift Supt.	Tire Co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	LaVale		554 National Highway/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Albert J. Rodenhauser	Laura V. Goss

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		214-05-9649	Mrs. Josephine Rodenhauser, LaVale, MD-wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Intracerebral hemorrhage	18 hours.
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebrovascular disease	24 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-11 19 85, to 12-19 19 85, that (I) (we) last saw the deceased alive on 12-19 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
William Lamm MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-19-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. William Lamm	Memorial Hospital Medical Building Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-22-1985	Rose Hill Cemetery	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 23 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon paper. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

353120

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32866

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Eldridge	P.	Saville	December 6, 1985	6:50P	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	04 27 93	92 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Augusta, W. Va.	USA		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	Lions Manor Nursing Home	retired	textile		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cumberland	YES ☒ NO ☐	402 Grand Ave., Cumberland, Md. 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	T.	Saville	Harriet	E.	Wolford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
yes	WW I	217-10-4146	Lions Manor Nursing Home, Cumberland, Md. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Senility

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Deep vein thrombosis. Status Post Carcinoma of Colon

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/20, 19 88, to 12/6, 19 85, that (I) (we) last saw the deceased alive on 12/4, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
V. A. Ranjithan	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Vimala Ranjithan, M.D.	Lions Manor Nursing Home, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-09-1985	Sunset Memorial Park	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James E. Scarpelli, Cumberland, MD 21502	DEC 11 1985	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

006174

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32867

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
MARY	N.	ROLLER SELF	DECEMBER 26, 1985	9:15A	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
female	white	05-08-1890	95 YRS.				

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
PA	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housewife	own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	125 Polk Street/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
David Roller	Catherine Hartman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		215-20-6508	Mrs. Charlotte Torbet, Cumberland, MD-daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) CVA + CAD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov. 25, 19 85 to Dec. 26, 19 85, that (I) (we) last saw the deceased alive on Dec. 25, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature] ws for Dr Bollino	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12-26-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. ANTHONY BOLLINO	955 Frederick St. Cumberland, Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12-28-1985	Friends Cove Cem.	Bedford PA

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 30 1985	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 1S, 4)

Kight

347047

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 85 32668

1. DECEASED NAME (TYPE OR PRINT): RUSSELL HENRY SHAFER
2a. DATE OF DEATH: December 5, 1985
2b. HOUR: 4:30 P.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Dec. 8, 1896
6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Va.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret.Owner
12b. KIND OF BUSINESS OR INDUSTRY: Auto Parts

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES X NO ☐
13e. STREET ADDRESS / ZIP CODE: 507 Conrad Ave. 21502

14. FATHER'S NAME: Clinton Shafer
15. MOTHER'S MAIDEN NAME: Nancy Frye
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 213-12-9773
17. INFORMANT ADDRESS: Anna Shafer, Cumberland, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bullous Pemphigus
DUE TO, OR AS A CONSEQUENCE OF (b): NSTD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO X
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 11 25 19 85 to 12 6 19 85 ; that (I) (we) last saw the deceased alive on ____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not (did) view the body after death.
22b. SIGNATURE: G. Fiscus DEGREE
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 12/6
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. G. Fiscus
22e. ADDRESS: Memorial Hospital Med. Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Dec.8,1985
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial P.
23d. LOCATION CITY OR TOWN: Cumberland COUNTY: Allegany STATE: MD
24. FUNERAL DIRECTOR (NAME) ADDRESS: William G. Kight Cumberland, MD
25a. DATE REC'D. BY REGISTRAR: DEC 11 1985
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH - 16 60M 7/84
(VRA 15, 4)

Male White Dec. 8, 1896 88

Va. USA XX

Ret.Owner Auto Parts

MD Allegany Cumberland X 307 Conrad Ave. 21502

Clinton Shafer Nancy Frye

Mo Anna Shafer, Cumberland, MD

Burial Dec.8,1965 Hillcrest Burial P. Cumberland Allegany MD

William G. Right Cumberland, MD

006220

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32869
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MICHAEL — MIDDLE: B. — LAST: SHEPARD

2a. DATE OF DEATH (MONTH DAY YEAR): DECEMBER 22, 1985

2b. HOUR: 0517 A M

3. SEX: Male

4. RACE: Cau

5. DATE OF BIRTH (MONTH DAY YEAR): June 25 1970

6. AGE (IN YEARS LAST BIRTHDAY): 15 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Student

12b. KIND OF BUSINESS OR INDUSTRY: --

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: WV — 13b. COUNTY: Mineral — 13c. CITY OR TOWN: Keyser — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE: Rt 2 Box 63 26726 99999

14. FATHER'S NAME — FIRST: William — MIDDLE: A. — LAST: Shepard

15. MOTHER'S MAIDEN NAME — FIRST: Susan — MIDDLE: R. — LAST: Barse

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): --

16b. SOCIAL SECURITY NO.: 800-04-6870

17. INFORMANT: William A. Shepard — ADDRESS: 216 W. Douglass St. Reading, PA 19601

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Muscular Dystrophy

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☑

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19: N/A

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐: N/A

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): N/A

21f. LOCATION — STREET / CITY OR TOWN / COUNTY / STATE: N/A

22a. I certify that (I) (this hospital) attended the deceased from 12/23/85, 19__, to __, 19__, that (I) (we) last saw the deceased alive on 12/23/85 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [illegible signature]

DEGREE

ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/24/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. SHAN NATHAN

22e. ADDRESS: MEDICAL BUILDING MEMORIAL HOSPITAL, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 12/28/85

23c. NAME OF CEMETERY OR CREMATORY: Omps Cremation Service

23d. LOCATION — CITY OR TOWN: Winchester — COUNTY: — STATE: VA

24. FUNERAL DIRECTOR — NAME: A. Craig Rotruck — ADDRESS: 85 S Main St Keyser, WV 26726

25a. DATE REC'D. BY REGISTRAR: DEC 31 1985

25b. REGISTRAR'S SIGNATURE: [illegible signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other [illegible] event, the medical examiner must be notified at once.

99999

BP

DHMH - 16 60M 7/84 (VRA 15.4)

353060

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 32870

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR	2b. HOUR
Diana	Mae	Shirley	12/11/1985	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Female	White	Oct. 9, 1945	40 YRS.			12/11/1985	8:22 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Penna.	U.S.A.		Allegany County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Frostburg Hospital	Clerk	County Gvt.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Frostburg	YES ☒ NO ☐	240 Center St., 21532

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Frederick W. Walker	Freda House

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	202-38-8488	Christina Shirley, Same as 13e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple Injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

8120

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	? P.M. 12/11/1985	driver in auto/auto collision

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
	roadway	Rt. 36, southbound, Allegany Co., Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12/11/85

EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Dec. 13 '85	Salisbury Cemetery	Salisbury, Penna.

24. FUNERAL DIRECTOR NAME ADDRESS: Durst Funeral Home, Frostburg, Md.

25a. DATE REC'D. BY REGISTRAR: DEC 16 1985

25b. REGISTRAR'S SIGNATURE: Julia Davidson Kopasz

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

009061

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32871

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the entire remaining portion (pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
IVA	MUREL	SHOEMAKER	December 31, 1985	7:35 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Dec. 9 1934	51 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia	U.S.A.		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	Memorial Hospital	Inspector	Poultry Mkt. Rockingham		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
WV	Hampshire	Romney	YES ☒ NO ☐	176 South High Street 99999	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
Clarence Barr			Grace Wilfong		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		236-50-0661	Cheryl Rotruck, 330 Wirgman Ave., Romney, WV		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular fibrillation

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost

DUE TO, OR AS A CONSEQUENCE OF (b) Fulminant cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/30 19 85 to 12/31 19 85, that (I) (we) last saw the deceased alive on 12/31 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Halmos DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 1/7/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Peter Halmos

22e. ADDRESS Memorial Hospital & Medical Center Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	1/3/86	Old Pine Cemetery	Purgitsville Hampshire WV
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Keith S. Shaffer Shaffer Funeral Home, Romney, WV 26757		JAN 8 1986	Julia Davidson Randall

999999

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

364167

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 328712
REG. NO.

Field	Entry
1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	JAMES ELWOOD SMITH
2a. DATE OF DEATH MONTH DAY YEAR	December 18, 1985
2b. HOUR	9:20 AM
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	Aug. 14, 1909
6. AGE (IN YEARS LAST BIRTHDAY)	76 YRS.
IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	WV
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Widowed
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.
10. CITY OR TOWN OF DEATH	Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Contractor
12b. KIND OF BUSINESS OR INDUSTRY	Construction
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	WV
13b. COUNTY	Hampshire
13c. CITY OR TOWN	Springfield
13d. INSIDE CITY LIMITS? YES ☐ NO ☒	NO
13e. STREET ADDRESS / ZIP CODE	Rt. 1, Box 2 A 99999
14. FATHER'S NAME FIRST / MIDDLE / LAST	Ace Albert Smith
15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Ada Malcolm
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO
(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	214-05-9085
17. INFORMANT / ADDRESS	Edith Smith, Star Rt. 1, Box 2 A Springfield, WV

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c)) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) End stage ischemic cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF

(b) Diabetes

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from ________, 19____, to ________, 19____ that (I) (we) last saw the deceased alive on ________ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H C Merrick — DEGREE — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/18/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. H.C. Merrick

22e. ADDRESS: Medical Building, Memorial Hospital Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/21/85	Wesley Chapel Cemetery	Points Hampshire WV

24. FUNERAL DIRECTOR NAME / ADDRESS: Keith S. Shaffer, Shaffer Funeral Home, Romney, WV

25a. DATE REC'D. BY REGISTRAR: DEC 23 1985 | 25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon... and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

999999

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

353169

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 32813

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 PART I. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM OF AUTHORIZATION. PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST
Cecilia	M.	Spates

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ — MONTH 12 DAY 5 YEAR 1985 — 2b. HOUR 2 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	Aug. 23, 1902	83 YRS.				

2c. DATE PRONOUNCED DEAD — MONTH 12 DAY 5 YEAR 1985 — 2d. HOUR 11:20 A M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	76 Broadway	Supervisor	U.S.Govt.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Frostburg	YES ☒ NO ☐	76 Broadway, 21532

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Frank	P.	Spates	Margaret		Carney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	224-60-6479	Frank Spates, Westminister, Cal.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Francisco Reyes M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-5-85

EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes, M.D. ADDRESS 900 Seton Dr., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Dec. 9 '85	St. Michaels Cem.	Frostburg, Allegany, Md.

24. FUNERAL DIRECTOR NAME ADDRESS: Durst Funeral Home, Frostburg, Md

25a. DATE REC'D. BY REGISTRAR DEC 13 1985

25b. REGISTRAR'S SIGNATURE Julia Davidson Rogers

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

364099

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 32374

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF POSSIBLE. AN AUTOPSY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX / ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Willie	C	Sponaugle	12	21	85	1055A
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Male	Cau	8 26 05	80 YRS.			12 21 85	1055A

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
W. Va.	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Bottler Ret.	Brewing Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS
Maryland	Allegany	Cumberlnd		701 Elm Street 21502

14. FATHER'S NAME FIRST / MIDDLE / LAST		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	
Ashby	Sponaugle	Mary C.	Munlix
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS
No	214-05-4778	Corda Sponaugle	Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-pulmonary arrest	sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Hepato-renal failure	2-3 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Chronic alcoholic liver disease	years

8880

Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause lost.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

Chronic sub-dural hematoma; coronary artery heart disease; chronic heart failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO XX

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH XX	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1400 P.M. 11 8 1985	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pt fell at home. Sub-dural. Pt fell again in hospital 12/10/85 0330hrs
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 11/8/85 701 Elm Street.	21f. LOCATION STREET 12/10/85 3 South CITY OR TOWN Memorial Hospital COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry XX, and in my opinion death resulted from: Natural couse XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐,

ACTUAL SIGNATURE Paul Snow, M.D. TITLE (SPECIFY) M.D. Dpty MEDICAL EXAMINER DATE SIGNED 12/21/85

EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D. ADDRESS Memorial Hospital Cumberland Maryland 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Burial	Dec. 24, 1985	Pleasant Grove C.	Cumberland	Allegany MD
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
William G. Kight	Cumberland, MD	DEC 26 1985		

07/84 25M BP ____ DHMH - 17 (VR A15 ME (5))

N. Va. USA

Bottler Ret. Brewing Co.

21502

Ashby Spongwie Mary C. Nunlix

No Corda Spongwie Same as above

Burial Dec. 24, 1985Pleasant Grove C. Cumberland Alleghany MD

William G. Knight Cumberland, MD

353130

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 85 32875

1. DECEASED NAME (TYPE OR PRINT): Charles W. Stansberry

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 12-2 DAY YEAR 19 85

2b. HOUR: M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH Aug. DAY 28, YEAR 1928

6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12-2 DAY YEAR 19 85

2d. HOUR: 2:04 p.m

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany County, MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Professor

12b. KIND OF BUSINESS OR INDUSTRY: College

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Frostburg

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 13 Park Ave., 21532

14. FATHER'S NAME: David F. Stansberry

15. MOTHER'S MAIDEN NAME: Trevia Kinney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): 1949-52

16b. SOCIAL SECURITY NO.: 232-40-8844

17. INFORMANT ADDRESS: Harrisville, W.VA. 26362 Records: Raiguel Funeral Home & Betty Stansberry-Frostburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES XX NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR 2:00 P.M. MONTH 12-2 DAY YEAR 19 85

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): subject pinned between autos

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK XX

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): road-east lane

21f. LOCATION STREET: Rt. 48, CITY OR TOWN: Cumberland, COUNTY: Allegany Co., STATE: Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy XX, Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident XX, Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Thomas D. Smith M.D. TITLE (SPECIFY): Acting Chief MEDICAL EXAMINER DATE SIGNED: 12-2-85

EXAMINER'S NAME (TYPE OR PRINT): Thomas D. Smith, M.D. ADDRESS: 111 Penn St., BAlto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Dec.6,1985

23c. NAME OF CEMETERY OR CREMATORY: Lawford Cemetery

23d. LOCATION CITY OR TOWN: Newberne COUNTY: Ritchie STATE: W.Va.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Durst Funeral Home, Frostburg, Md. 21532

25a. DATE REC'D. BY REGISTRAR: DEC 10 1985

25b. REGISTRAR'S SIGNATURE: Julia Davidson Rinehart

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH-MH 17. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

365225

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32876

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR / 2b. HOUR
Martin	BURKE	Sharp	12	17	85 / 11:25 A
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
MALE	WHITE	MARCH 9 1912	73 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH		
PA.	USA		Allegany		MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	Sacred Heart Hospital		RETIRED KELLY SPRINGFIELD TIRE CO		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	835 GEPHART DRIVE 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
H.	HALL	SHARP	MARY	M.	MARTIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES WWII	220-10-4290	MARIAN SHARP 835 GEPHART DRIVE CUMBERLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Mayocardial acute MI

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Diabetes Mellitus, chronic CVA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) last attended the deceased from Nov. 26 19 85 to Dec. 16, 19 80 Dec. 17, 19 85, that (I) (we) saw the deceased alive on Nov. 26 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Williams MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	Dec. 18, 1985

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR TERRY WILLIAMS	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	DEC 20 1985	rest lawn cemetery	LAVALE ALLEGANY MARYLAND

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND	DEC 23 1985	Julia Davidson Rondelle

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

010059

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32877

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Paul	W	Steinberger	December 31, 1985	M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	Dec. 1, 1897	88 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
Germany	U.S.A.		Allegany County MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	803 Tanpley Avenue	Salesman	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Cumberland	YES XX NO ☐	803 Tanpley Ave. 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Gustau		Steinberger	unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	---	214-05-8329	Milly G. Steinberger same as 13a-e

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma of the Liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

DUE TO, OR AS A CONSEQUENCE OF

(b) Primary Carcinoma of the kidneys — 6 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cysts both kidneys -CVA - Coronary Arteriosclerosis-Auricullar

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO XX	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/18/51, 19 51, to 12/31/, 19 85, that (I) (we) last saw the deceased alive on 12/31, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	MD		1-2-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
SAMUEL M. JACOBSON, MD.	50 PERSHING ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	1/2/86	Eastview Cemetery	Cumberland	Allegany	MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leasure-Stein Funeral Home, Inc.	230 Baltimore Ave. Cumberland, MD 21502	JAN 8 1986	[signature]

DHMH-16 60M 1/73
(VR A 15 (4))

006169

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32878

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the items on this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Marguerite	MIDDLE: E.	LAST: Stinger	2a. DATE OF DEATH MONTH DAY YEAR: December 24, 1985	2b. HOUR: 7:08pm
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: 03-26-1904	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.	
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hosp. & Med. Bldg.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): supervisor	12b. KIND OF BUSINESS OR INDUSTRY: telephone co.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	135 N. Mechanic Street/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Clarence F. Fraley	Anna Marie Sweitzer	no	214-05-8994	Mr. Walter D. Stinger, Orlando, FL - son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial acute MI

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) CAD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from Dec. 24 85 to Dec. 24 85, that (I) (we) last saw the deceased alive on Dec. 24 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
William D Lamm	MD	☐ ☒ ☐	12-26-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. William D. Lamm	Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-27-1985	Hillcrest Burial Park	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 30 1985	John Davidson Register

006173

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32879 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MILDRED	LOUISE	TALLMAN	December 27, 1985	9:45 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
female	white	06-15-1912	73 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
OH	USA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	retired	restaurant

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cresaptown	YES ☐ NO ☒	Route 6 Box 371/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
James Keplinger	Hazel Millirons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		213-24-6668	Mrs. Ann Pratt, Cresaptown, MD - daughter

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intractable Congestive Cardiac Failure.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Cardiomyopathy.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Digitalis Intoxication

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐ ☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
	MD	☐ ☒ ☐	12/27/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Ranjithan	Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-29-1985	St. Joseph Cemetery	Midland Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 30 1985	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

352016

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32080

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Louise	Bright	Teter	12/11/85	7:05 AM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	June 30, 1906	79 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
W.VA.	USA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	635 Apt. 4B Washington St.	Housewife	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cumberland	YES ☒ NO ☐	635 Apt. 4B Wash.St./21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles	E.	Bright	Lulah	Katherine	Rinehart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		220-44-2623	Harry Teter, Jr.	4512 Hoban Road NW Washington, D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Anasarca

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Hypoalbuminemia - Malnutrition

DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Breast CA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
K Merrick	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
H. Curtiss Merrick M.D.	Cumberland, Maryland 21502 500 Memorial Hospital, Medical Blg

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12/13/85	Queens Point Ceme.	Keyser, Mineral, W. VA.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr. LaVale, MD	DEC 16 1985	Christine Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, even the medical examiner has notified or given

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

006152

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32881
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: MARY	MIDDLE: ELIZABETH	LAST: TRAIL	2a. DATE OF DEATH MONTH: DECEMBER	DAY: 26	YEAR: 1985
2b. HOUR: 2 AM M					
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH: MAY	DAY: 11	YEAR: 1910	6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN.:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.		
10. CITY OR TOWN OF DEATH: LITTLE ORLEANS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): AT HOME RFD#1	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSE WIFE	12b. KIND OF BUSINESS OR INDUSTRY: -----		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: LITTLE ORLEANS	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: RFD#1 20760	
14. FATHER'S NAME FIRST: CECIL	MIDDLE: U.	LAST: SCHRIVER	15. MOTHER'S MAIDEN NAME FIRST: RUSSCELLA	MIDDLE:	LAST: HILL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-60-1022	17. INFORMANT ADDRESS: DARHL TRAIL STAR ROUTE FLINTSTONE MD 21530		

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19 82, to Nov 19 85, that (I) (we) last saw the deceased alive on Nov 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robertiano J. Barrera, L — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12-26-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. ROBUSTIANO J. BARRERA

22e. ADDRESS: MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: DEC29,1985	23c. NAME OF CEMETERY OR CREMATORY: PINEY PLAINS CEMETERY	23d. LOCATION CITY OR TOWN: PINEY PLAINS / COUNTY: ALLEGANY / STATE: MARYLAND
24. FUNERAL DIRECTOR NAME / ADDRESS: SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND	25a. DATE REC'D. BY REGISTRAR: DEC 30 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson Rondelle	

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

007096

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32882 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH	DAY	YEAR	2b. HOUR
Olive	Jane	Twigg	12	29	85	9:15 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Jan. 9, 1892	93 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Lion's Manor Nursing Home	Housewife	Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Corriganville	YES ☐ NO X	Rt. # 1, 21524

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Charles		Allen	Florence	A.	Cassidy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		212-74-9809	Gwendolyn McCray, Baltimore, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Upper G.I bleeding, Ventricular irritability

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-29, 1983, to 12-29, 1985, that (I) (we) last saw the deceased alive on ____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED
V. A. Ranjithan		12-30-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
V. A. Ranjithan, M. D.	L.M.N.H. Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Jan. 2, 1986	Sunset Memorial P.	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
William G. Kight	Cumberland, MD	JAN 3 1986	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by law.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

Female	White	Jan. 9, 1892	93
MD	USA		

Cumberland	Lion's Manor Nursing Home			Housewife	Own Home
MD	Allegany	Corriganville	x	Rt. # 1, 21524	
Charles	Allen	Florence	A.	Cassidy	
No	Gwendolyn McCray, Baltimore, MD				

Burial	Jan.2,1986 Sunset Memorial P. Cumberland Allegany MD
William G. Kight	Cumberland, MD

Silcox

008118

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32885

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return ban poppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: KATE	MIDDLE: D	LAST: VANCE	2a. DATE OF DEATH MONTH DAY YEAR: December 28, 1985	2b. HOUR: 10:02 P. M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JAN 9 1902	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W.VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.	
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: ---
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FLINTSTONE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: RFD#1 BOX# 379 21530
14. FATHER'S NAME FIRST: JOHN	MIDDLE	LAST: DAY	15. MOTHER'S MAIDEN NAME FIRST: MYRA	MIDDLE	LAST: BRICKER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220-03-7170 D	17. INFORMANT ADDRESS: EVELINE COLLIER RFD 1 FLINTSTONE MARYLAND	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	
DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 12/27, 19 85, to 12/28, 19 85, that (I) (we) last saw the deceased alive on 12/28, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. William P. Iames	22e. ADDRESS: 441 N. Centre Street Cumberland, MD 21502		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 31 DEC 1985	23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CHRISTIAN CEMT	23d. LOCATION CITY OR TOWN / COUNTY / STATE: INGLESMITH BEDFORD PENNA.	
24. FUNERAL DIRECTOR NAME / ADDRESS: SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND		25a. DATE REC'D. BY REGISTRAR: JAN 2 1986	25b. REGISTRAR'S SIGNATURE: [signature]	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

006204

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32884

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove [illegible] pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
EDNA	JANE	WALTERS	December 21, 1985	7:10a. M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JANUARY 5, 1915	70 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		ALLEGANY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland	MEMORIAL HOSP. & MEDICAL CENTER	CLERK	GROCERY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	MT. SAVAGE	YES X NO ☐	FOUNDRY ROW, 21545 (BOX 423)

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
WILLIAM		GRIFFITH	CATHERINE		HARTIG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		216-22-6692	CHARLES E. WALTERS, SAME AS 13e	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease

DUE TO, OR AS A CONSEQUENCE OF (c) N/A

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c): N/A

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
N/A	N/A	YES ☐ NO ☑	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
N/A	N/A	N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
N/A	N/A	N/A			

22a. I certify that (I) (this hospital) attended the deceased from 12/22/85, 19____, to ____, 19____, that (I) (we) last saw the deceased alive on 12/22/85, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/24/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. James Raver	Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL	DEC. 23 '85	METHODIST CEMETERY	MT. SAVAGE,	ALLEGANY,	MD.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME,	FROSTBURG, MD. 21532	DEC 31 1985	Julia Davidson-Rogers

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

364131

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32883

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper(s). Pages 1 and 2 are to be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b HOUR
MABEL	MARGIE	WATKINS	December 11,1985	7:50 P.M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
female	white	05-22-1899	86 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USa		Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	housewife	own home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	814 Sylvan Avenue/21502

14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
James R. Stump	Anna Belle Robey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	219-14-7476	Mr. Robert S. Watkins, Cumberland, MD - son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory arrest	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	CA Pancreas	1-2 yr
DUE TO, OR AS A CONSEQUENCE OF (c)	Uremic gastroenteritis	2 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12-11, 19 84, to 12-11, 19 84, that (I) (we) last saw the deceased alive on 12-11, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
[signature]	M D		12-12-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Terry Williams	Memorial Hospital Medical Bldg. Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12-14-1985	Hillcrest Burial Park	Cumberland Allegany MD

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 19 1985	[signature]

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Shaffers Funeral Home
230 E. Main Street
Romney, WV 26757

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32886

013099

1. DECEASED NAME (TYPE OR PRINT): Max Eugene Waye
2a. DATE OF DEATH: December 31, 1985
2b. HOUR: 3:40A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Aug. 17 1928
6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Indiana
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany County, MD.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Sacred Heart Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Service Man
12b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: WV
13b. COUNTY: Hampshire
13c. CITY OR TOWN: Romney
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS / ZIP CODE: P. O. Box 339 99999
14. FATHER'S NAME: Silas Waye
15. MOTHER'S MAIDEN NAME: Blanche Marie Waye
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes
IF YES, GIVE WAR OR DATES: World War II
16b. SOCIAL SECURITY NO.: 310248519
17. INFORMANT: Constance K. Way
ADDRESS: P. O. Box 339, Romney, WV 26757

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Lung Cancer
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 months
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/19/85 to 12/31/85, that (I) (we) last saw the deceased alive on 12/31/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD
DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 12/31/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Richard Schmitt, M.D.
22e. ADDRESS: 900 Seton Dr Dept Of Pulmonary Medicine, SHH, Cumberland md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
23b. DATE: 1/1/86
23c. NAME OF CEMETERY OR CREMATORY: Omps Cremation Service
23d. LOCATION CITY OR TOWN: Winchester COUNTY: Frederick STATE: Va.
24. FUNERAL DIRECTOR NAME: Keith S. Shaffer
ADDRESS: Shaffer Funeral Home, Romney, WV
25a. DATE REC'D. BY REGISTRAR: JAN 7 1986
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

361022

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 3 2 8 8 7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN SECTION ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST
ESTELLA	A.	WEBB

2a. DATE OF DEATH KNOWN ☐ ESTIMATED XX — MONTH DAY YEAR: 12-21-85 — 2b. HOUR: 4:00 a.m.

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	White	Feb. 10, 1896	89 YRS.		

2c. DATE PRONOUNCED DEAD (MONTH DAY YEAR): 12-21-85 19 — 2d. HOUR: 8:00 a.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	Allegany MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	2 Utah Avenue	Teacher-Nicholas Co. Bd. of Ed.	

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Allegany	Cumberland	YES X NO ☐	2 Utah Avenue / 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Cottle	B.	Kyer	Sarah	-	Hamon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
--	--	217-10-5391D	Aubrey Webb - Address same as #13 above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF JAW
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO X

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry XX, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Giovanni Mastrangelo M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-21-85

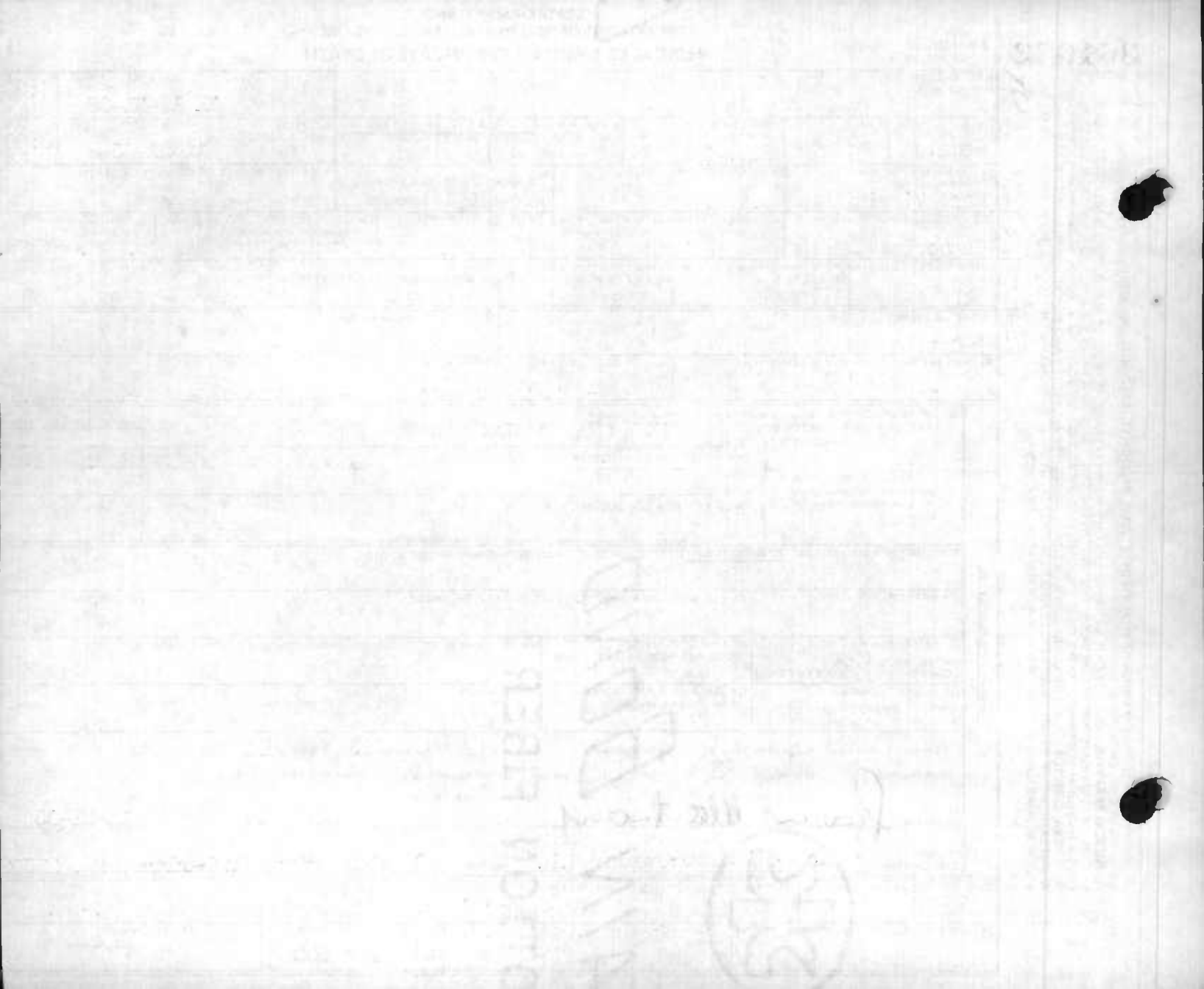
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D. ADDRESS 900 Seton Drive, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-23-85	Hillcrest Burial Park	Cumberland-Allegany Co.-Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George-Upchurch Funeral Home, p.A. 202 Greene Street-Cumberland, Md. 21502	DEC 24 1985	

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



353052

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32 8 8 8

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	RANSOM C WERTZ	2a. DATE OF DEATH MONTH DAY YEAR	DECEMBER 8, 1985	2b. HOUR	12:00P.M.
3. SEX	male	4. RACE	white	5. DATE OF BIRTH MONTH DAY YEAR	04-25-1906
6. AGE (IN YEARS LAST BIRTHDAY)	79 YRS	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	PA	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	
9. BALTIMORE CITY OR COUNTY OF DEATH	Allegany MD.				
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	retired
12b. KIND OF BUSINESS OR INDUSTRY	textile				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Allegany	Cumberland	YES ☒ NO ☐	307 Jefferson Street/21502

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Valentine Wertz	Arrena T. Bennett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		217-10-6555	Mrs. Goldie M. Lewis-Greenspring, WV

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis due to Pneumonia,

DUE TO, OR AS A CONSEQUENCE OF (c) probably UTI & Cellulitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe Malnutrition and Chronic Anemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/8/1985 to 12/8/1985 that (I) (we) last saw the deceased alive on 12/8/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Nathan Nathan	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	12/10/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DR. NATHAN	MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-11-1985	Chaneysville Cemetery	Chaneysville PA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, MD 21502	DEC 16 1985	Julia Swisher Powell

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma, the medical examiner must be notified before disposition.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remit pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal from the state.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

353124

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 85 32889

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST: LUCY	MIDDLE: MARIE	LAST: WHETZEL	2a. DATE OF DEATH MONTH DAY YEAR: December 7, 1985	2b. HOUR: 4:00 pm	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH MONTH DAY YEAR: 09-04-1913	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): VA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired	12b. KIND OF BUSINESS OR INDUSTRY: Tire Co.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 12807 Bunting Street S.W./21502	
14. FATHER'S NAME FIRST MIDDLE LAST: Clyde A. Ballow		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Kate M. Powell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219-14-6847	17. INFORMANT ADDRESS: Mr. John W. Whetzel, Cumberland, MD - son			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiopulmonary arrest	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Massive CVA	2 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Atherosclerosis	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): acute MI; operation

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that I (this hospital) attended the deceased from 12-5, 19 85, to 12-7, 19 85, that I (we) last saw the deceased alive on 12-5, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 12-10-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Bollino	22e. ADDRESS: 955 Frederick St. Cumberland, MD 21502		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 12-10-1985	23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME ADDRESS: James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR: DEC 12 1985	25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

360026

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 85 3 2 6 9 0

1. DECEASED NAME (TYPE OR PRINT): FIRST Bertram; MIDDLE F; LAST Whisler

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☑ — MONTH 12 DAY 9 YEAR 19 85 — 2b. HOUR 10:8 M

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH June DAY 25 YEAR 1927 — 6. AGE (IN YEARS, LAST BIRTHDAY): 58 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 12 DAY 12 YEAR 19 85 — 2d. HOUR 1:15 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY MD.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Residence

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): STATISTICIAN - U.S. GOVERNMENT

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: 21502- Md. — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Cumberland — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 427 N. Centre Street / 21502

14. FATHER'S NAME: FIRST Russel; MIDDLE; LAST Whisler

15. MOTHER'S MAIDEN NAME: FIRST Louise; MIDDLE; LAST Hummel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): --

(IF YES, GIVE WAR OR DATES): --

16b. SOCIAL SECURITY NO.: 201-16-3285

17. INFORMANT — ADDRESS: 17101 Queen Victoria Ct

Edna Whisler Gaithbersburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Francisco Reyes — TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER — DATE SIGNED 12-12-85

EXAMINER'S NAME (TYPE OR PRINT): Francisco Reyes — ADDRESS 900 Seton Dr. Cumberland Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: 12-14-85

23c. NAME OF CEMETERY OR CREMATORY: Rosedale Funeral CHAPEL

23d. LOCATION CITY OR TOWN: Martinsburg — COUNTY: BERKELEY — STATE: W.Va.

24 FUNERAL DIRECTOR NAME AND ADDRESS: George-Upchurch Funeral Home, P.A. 202 Green Street, Cumberland, Md. 21502

25a. DATE REC'D. BY REGISTRAR: DEC 23 1985

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

353057

Silcox-Merritt Funeral Home
1 - FOR STATE REGISTRAR 404 Decatur Street Cumberland, MD 21502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32891
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Jennie	Josephine	Wilson	December 11, 1985	10:50PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
FEMALE	WHITE	SEPT 7 1930	55 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	USA		Allegany County, MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	Sacred Heart Hospital	McCROYS DEPT STORE CLERK	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	537 FAIRVIEW AVE CUMBERLAND MD. 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
JOHN		PULLEM	MANDA		(INK)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		215267110	WILLIAM WILSON 537 FAIRVIEW AVE CUMBERLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Endstage Adenocarcinoma of Pankreas	
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
G Wagoner MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐	12-13-85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Gary Wagoner, M.D.	925 Bishop Walsh Road, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	DEC 16 1985	ROCKY GAP VETERANS CEMT	FLINTSTONE ALLEGANY MD

24. FUNERAL DIRECTOR NAME	ADDRESS	25. DATE ACCEPTED BY REGISTRAR	REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL SERVICE	CUMBERLAND MARYLAND	DEC 6 1985	Julia Davidson Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please see that the remaining copies are completed. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83
(VRA 15, 4)

353144

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32692

REG. NO.

1 - FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
RETA	VIRGINIA	WILSON	DECEMBER 7, 1985	3:10PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JUNE 28 1901	84 YRS		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
W.VA.	USA	MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	ALLEGANY COUNTY MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	SCHOOL - TEACHER

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND	ALLEGANY	CUMBERLAND	YES ☐ NO XX	RFD# 3 VALLEY ROAD 21502

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
MILLARD F. BARTLETT	VIRGINIA CARTWRIGHT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		217-54-6295	OSCAR WILSON	RFD# 3 VALLEY ROAD CUMBERLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiogenic shock	24 hr.
DUE TO, OR AS A CONSEQUENCE OF (b)	Recent acute MI	1 mo.
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized Arteriosclerosis	years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pneumonitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO X	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from Dec. 1, 19 85, to Dec. 7, 19 85, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
[signature]	MD	ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	12/10/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
V. EUGENE MAZZOCCO — Dr Miles	BMG, 912 SETON DRIVE CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
BURIAL	DEC 11 1985	SUNSET MEMORIAL PARK	CUMBERLAND ALLEGANY MARYLAND

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL HOME CUMBERLAND MARYLAND	DEC 13 1985	[signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 (a) or any injury, or other traumatic event, the medical examiner must be notified before burial.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

361031

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32693
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN	MIDDLE: DANIEL	LAST: WINTERS	2a. DATE OF DEATH MONTH DAY YEAR: DECEMBER 19, 1985	2b. HOUR: 10:00A. M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: January 31,1927	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Allegany MD.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Kelly-SPringfield	12b. KIND OF BUSINESS OR INDUSTRY: Tire Company		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Allegany	Cresaptown	YES XX NO ☐	13601 Fir Tree Lane / 21502

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Osbey	-	Winters	Mae	-	Phillips

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	W.W.II	216-22-6754	Merle L. Winters-Address same as #13 above.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLISM

DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY INFARCTION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PERFORATING PEPTIC ULCER

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☑ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-28 19 85 to 12-19 19 85 that (I) (we) last saw the deceased alive on 12-19 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 12/19/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DR. TORRES

22e. MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	12-21-85	Hillcrest Burial Park	Cumberland-Allegany Co.,-Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502	DEC 24 1985	[signature]

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

364155

FOR 1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 85 3 2 8 9 4

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ MONTH	DAY	YEAR	2b. HOUR
Mary	Alice	Wolford	12	20	1985	1220 P M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	2d. HOUR
Female	White	Jan 21, 1898	87 YRS.			12 20 1985	1220 P. M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH				
W. Va.	U.S.A.		Allegany MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland	Sacred Heart Hospital	Homemaker	--				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET ADDRESS			
W. Va.	Mineral	Keyser		500 Carskadon Lane			
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST		
Charles	W.	McKenzie	Margaret	Ann	Fleek		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
No		234 44 6625	Carl Wolford	Rt 1 Box Chandler, Texas			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	arteriosclerotic heart disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO XX
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry XX and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Giovanni Mastrangelo M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-20-85

EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D. ADDRESS 900 Seton Drive, Cumberland, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY / STATE
Burial	23 Dec 85	Queens Point	Keyser	Mineral W. Va.
24. FUNERAL DIRECTOR NAME / ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Allen Rotruck Keyser, W.Va.		DEC 26 1985	Julia Davidson-Randall	

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

340132

1 - FOR STATE REGISTRAR

Eichorn Funeral Home
Main Street
Lonaconing, MD 21539

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 32895
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Helen	Cecelia	Woods	12-01-85	8:57 p

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Sept. 11, 1918	67 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH
MD	USA	NEVER MARRIED [X]	allegany county MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	Homemaker	Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Allegany	Lonaconing	YES [ ] NO [X]	2 St. Marys Terrace 21539

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Terence	T.	Woods	Frances		Grimes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	213182040	Frances Lipphold	Rt8, Box 152 Cumberland Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	5 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial infarction	1 hr
DUE TO, OR AS A CONSEQUENCE OF (c)	arteriosclerotic cardiovascular	many yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible], to [illegible] 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible], and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	12/2/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Donald Manger, M.D.	55 Jackson Street, Lonaconing, MD 21539

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Dec. 4, 1985	Sunset Mem. Park	Cumberland Allegany MD

24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Eichhorn Funeral Home, Lonaconing, Md.	DEC 4 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)